DOCUMENT RESUME

ED 028 769 JC 690 120

An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: Workshop Report.

National League for Nursing, New York, N.Y. Mental Health and Psychiatric Nursing Advisory Service.
Spons Agency-National Inst. of Mental Health (DHEW), Bethesda, Md.
Report No-NLN-33-1288
Pub Date 67
Note-69p.
Available from-National League for Nursing, Mental Health and Psychiatric Nursing Advisory Service, 10 Columbus Circle, New York, New York 10019 ($1.50)
EDRS Price MF-$0.50 HC Not Available from EDRS.
Descriptors-*Junior Colleges, *Mental Health, *Nurses Aides, Nursing, *Occupations, *Psychiatric Aides

This workshop was the third and final phase of a project to determine what goals, methods, content, and learning experiences in psychiatric-mental health nursing should be included in diploma and associate degree education for nursing in light of present day trends in psychiatric care. The project indicates that the hospital is no longer the focal point of psychiatric care and the community is very much involved in mental health activities. Nurses need to be involved in learning experiences that include the whole mental health continuum. The first phase of the project was the selection of eight diploma and eight associate degree educational programs in nursing to participate in the study. The second phase was the selection of content and learning experiences appropriate to both programs. The purpose of the workshop was to prepare faculties to use the project method of planning a course in nursing care. This summary of the 5-day workshop includes (1) integration of psychiatric-mental health nursing content in a curriculum, (2) individual behavior and the nurse-patient relationship, (3) the group process, (4) therapeutic environment, (5) the trend toward community mental health centers, (6) 31 selected operational definitions, and (7) workshop materials. A bibliography is organized into (1) curriculum development, (2) ward environment, (3) group work skills, and (4) community mental health trends. (RM)

ED028769

An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs:

Workshop Report

NATIONAL LEAGUE FOR NURSING

1967

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AN APPROACH TO THE TEACHING OF PSYCHIATRIC NURSING IN DIPLOMA AND ASSOCIATE DEGREE PROGRAMS:

WORKSHOP REPORT

This project was supported in part by training grant number 8230-04 from the National Institute of Mental Health, U. S. Public Health Service.

The workshop was held in New York City in October, 1966.

NATIONAL LEAGUE FOR NURSING
Mental Health and Psychiatric Nursing Advisory Service
10 Columbus Circle, New York, New York 10019

1967

Code Number: 33-1288 Price: $1.50

UNIVERSITY OF CALIF.
LOS ANGELES

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PRINTED IN THE UNITED STATES OF AMERICA

CONTENTS

INTRODUCTION AND OVERVIEW OF THE WORKSHOP PROCEEDINGS 1
Joan E. Walsh

PSYCHIATRIC-MENTAL HEALTH NURSING ACTIVITIES OF THE NATIONAL LEAGUE FOR NURSING 3
Mary F. Liston

PROGRESS REPORT ON THE PROJECT 6
Joan E. Walsh

INTEGRATION OF PSYCHIATRIC-MENTAL HEALTH NURSING CONTENT IN A CURRICULUM 9
Mona Moughton

WORKSHOP PLANS AND INSTRUCTIONS FOR PARTICIPANTS 16
Joan E. Walsh

INDIVIDUAL BEHAVIOR AND THE NURSE-PATIENT RELATIONSHIP 18
Cecelia A. Monat

THE GROUP PROCESS 25
Cecelia A. Monat

THERAPEUTIC ENVIRONMENT. 29
Joan E. Walsh

THE TREND TOWARD COMMUNITY MENTAL HEALTH CENTERS 32
Wallace Mandell

SUMMARY OF PARTICIPANTS' REPORTS 40

APPENDIXES

A. Selected Operational Definitions 45

Continued

Contents--Continued

B. Workshop Materials
1. Questions for Faculty Discussion Prior to the Workshop 56
2. Worksheets 57
3. Directions for Use of the Worksheets 58
4. Bibliography 59
5. Form for Participants' Evaluation of the Workshop 61
C. Workshop Agenda 62
D. Roster of Workshop Participants 64

INTRODUCTION AND OVERVIEW OF THE WORKSHOP PROCEEDINGS

Joan E. Walsh

The workshop was planned as part of the third phase of the NLN demonstration pilot project entitled "An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs." The project is sponsored by the National Institute of Mental Health. The purpose of the project is to improve the teaching of psychiatric nursing in diploma and associate degree programs in the belief that this will lead to better general nursing practice in all settings. To this end, the project is concerned with the integration of psychiatric-mental health nursing content throughout the curriculums of these two types of programs as well as with the inclusion of newer trends in the course or unit in psychiatric nursing. The method of approach has been to determine objectives relating to the above aspects for technical-level nursing education programs and then to select appropriate content, learning experiences, and evaluation methods.

All of the planning and activities in the project have been based on the following major assumptions.

1. Technical-level education in nursing prepares the graduate for beginning first-level practice in nursing care of patients with major health problems.
2. Psychiatric-mental health nursing content is part of all clinical nursing content.
3. Psychiatric-mental health nursing content in the curriculum logically proceeds from the normal to the abnormal, from the simple to the complex, or from the obvious to the subtle.
4. Content from the psychosocial sciences forms a base for psychiatric-mental health nursing content.
5. A course or unit in nursing care of the mentally ill is included in the curriculum and is considered and managed in the same way as the other clinical courses.

The project plan included testing of the methods and the materials developed in the project through demonstration in selected nursing programs. The schools and departments represented at the workshop have agreed to participate in the project.

Prior to the workshop, faculties were made somewhat familiar with the project approach to planning for the integration of psychiatric-mental health nursing content and the course in psychiatric nursing through material sent to their programs for faculty discussion, through the progress report the directors received, and through the origi-

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nal visit by project staff to their programs. During the summer of 1966, faculties were sent a bibliography and a set of questions for their response. /See Appendix B./ The questions called for faculty agreement on the differences and the similarities between mental health and psychiatric nursing content, a description of the actual content in this area in their curriculums and its placement and sequence, and problems encountered in the integration of this content in their programs. In addition, they were asked to describe objectives, or expected competencies, related to this area. Faculties were also asked to trace an area of psychiatric-mental health nursing content through their curriculums. The readings and the questions were designed to prepare faculty representatives for their participation in the workshop.

The purpose of the workshop is to prepare representatives of the faculties of the participating programs for utilization of the project method of planning for integration of psychiatric-mental health nursing content in their curriculums and for subsequent planning for the course or unit in psychiatric nursing or nursing care of the mentally ill. In planning for the workshop, it was requested that the associate degree program faculty representatives be the instructor in nursing care of the mentally ill and the individual who worked most closely with her, and that the diploma program representatives be the instructor in psychiatric nursing and the person in charge of curriculum planning.

The activities of participants at the workshop include developing objectives, planning for content in the area of psychiatric-mental health nursing, and planning for their implementation in their own programs. As a follow-up on the workshop, project staff will visit the programs to assist faculties in implementing the plans made at the workshop by their representatives.

PSYCHIATRIC-MENTAL HEALTH NURSING ACTIVITIES OF THE NATIONAL LEAGUE FOR NURSING

Mary F. Liston

I have been asked to share with you the thinking and planning that has gone into the development of the NLN project "An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs," as well as to discuss briefly the activities of NLN in the field of psychiatric nursing.

As you are well aware, NLN has made a concerted effort to contribute to the development of mental health and psychiatric nursing. When the League was first organized in 1952, a Mental Health and Psychiatric Nursing Advisory Service was established within the staff structure. This service, under the capable direction of Kathleen Black, made great strides in attempting to define the needs, the problems, and the issues in mental health and psychiatric nursing.

One of the first individual membership councils established in NLN was the Council on Psychiatric and Mental Health Nursing. After 14 years of existence, there are 50 state and local councils, and almost 6,000 of the 25,000 NLN members are involved in council activities. I know all of you are familiar with the council's quarterly Newsletter. This publication has received wide acceptance in psychiatric circles. In order to further assist the improvement of psychiatric nursing services, The Correspondent, a quarterly newsletter for psychiatric aides, attendants, technicians, and practical nurses, was introduced in 1957. This is the only NLN newsletter that is offered on a subscription basis. Aides, attendants, practical nurses, and others contribute copy for publication in The Correspondent.

The activities of the Mental Health and Psychiatric Nursing Advisory Service and the Council on Psychiatric and Mental Health Nursing have been focused on the improvement and continuing development of psychiatric nursing services and psychiatric nursing education. Since our focus in this workshop is on psychiatric nursing education, I would like to review NLN activities that have been specifically concerned with education for psychiatric-mental health nursing.

The National League for Nursing, since its beginning, has been seriously concerned with the problem of education for psychiatric nursing. In 1953, the NLN Board of Directors indicated that "basic nursing education programs should prepare graduate nurses to care for psychiatric patients as well as for medical-surgical, obstetric, and pediatric patients." This was the first official statement by a nursing organization relative to the responsibility of preservice nursing programs to prepare beginning practitioners for psychiatric nursing.

In keeping with this expressed interest and philosophy, NLN, with generous financial assistance from the National Institute of Mental Health, has conducted projects and

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studies in the field of psychiatric-mental health nursing. The projects and studies were concerned with baccalaureate education, graduate education, and inservice education for professional nurses. These activities resulted in significant contributions to the development of psychiatric-mental health nursing.

One aspect of education for psychiatric nursing that has received relatively little attention from nursing educators is the provision of learning experiences in psychiatric-mental health nursing in diploma and associate degree programs. Some articles have appeared in the nursing literature, and limited studies concerning the nature of the learning experiences have been made. These have been primarily focused on diploma programs.

Much concern has been expressed about the difficulty of recruiting nurses for the field of psychiatric nursing. The report of the Joint Commission, Action for Mental Health, published in 1961, indicated that while all the psychiatric disciplines have serious manpower shortages, nursing is in the most acute need. The Joint Commission recommended:

> The mental health professions need to launch a national manpower recruitment and training program, expanding on and extending present efforts and seeking to stimulate the interest of American youth in mental health work as a career. This program should include all categories of mental health personnel. The program should emphasize not only professional training, but also short courses and on-the-job training in the subprofessions and upgrading for partially trained persons.[1]

It was in keeping with the intent of this recommendation that this project was proposed. Nursing has great potential as a source of mental health manpower. However, in the past, for a diversity of reasons, this manpower has been largely an untapped reservoir. Seventy-five percent, or 26,278, of the 35,125 nursing students graduated from schools of nursing in 1966 were from 822 diploma nursing programs.[2] In addition, 3,349 students were graduated from 218 associate degree programs. These 29,627 students are a vast potential resource for psychiatric nursing.

An important factor underlying the recruitment problem in psychiatric nursing is concerned with the student's first introduction to the field during her basic program. Studies have shown that in diploma programs especially this introduction may be entirely frustrating, even traumatic, to the student, since she is not provided with the expert guidance needed to develop satisfying, therapeutic relationships with patients. In addition, it might be expected that those who ultimately select psychiatric nursing as a career would have had a basic learning experience on which clinical expertness might be built through further education and experience. At the present time, nurses who elect to continue in psychiatric nursing have, for the most part, very inadequate grounding in the subject and require much supplementary assistance before they are ready for advanced study or experience that requires the ability to relate helpfully to patients. Consideration must also be given to the fact that the graduate of the diploma school or associate degree program must complete the requirements for the baccalaureate degree in nursing before she is eligible for admission to a master's program of specialization in psychiatric nursing.

The woefully inadequate recruitment of nurses for the field of psychiatric nursing indicates an imperative need for critical review of what is currently being offered as content and learning experiences in psychiatric nursing in preservice nursing programs.

Many of the current offerings are traditionally oriented, limited in depth and breadth of content, and without emphasis on the dynamic aspects of psychiatric nursing. They are primarily offered as "affiliation type" experiences.

In a study of diploma students, Long found that "there was a very marked association between degree of satisfaction with and during the psychiatric affiliation and level of preference for psychiatric nursing as a future career at the end of the affiliation. This relationship was a very strong one, and clearly indicates that reactions to the psychiatric affiliation are of great importance with respect to psychiatric nursing and future career choice."[3] Albee has suggested that "research is needed to determine whether changes in locus and program of the psychiatric affiliation, on an experimental basis, would result in increases in the number of student nurses recruited to the psychiatric field."[4]

The identification of content in psychiatric nursing is of tremendous importance. Changing methods and concepts of treatment of the psychiatric patient--including day-care centers, after-care clinics, follow-up care of discharged psychiatric patients and their families, new treatment programs in mental hospitals, emphasis on prevention of mental and emotional disorders--are developments that have created the need for fundamental changes in course offerings in psychiatric nursing.

The hospital is no longer the focal point of psychiatric care. The community is very much involved in mental health and psychiatric activities. Nurses need to be involved in learning experiences that include the whole mental health continuum--promotion of mental health, prevention of mental disorders, treatment and rehabilitation of the mentally ill. This type of involvement will lead to improved practice in all of nursing. With these factors to be considered, it seems important to define the goals, methods, content, and learning experiences for psychiatric-mental health nursing appropriate for diploma and associate degree nursing programs. Thus this project was developed.

The purpose of the study is to determine what goals, methods, content, and learning experiences in psychiatric-mental health nursing should be included in diploma and associate degree education for nursing in light of present-day trends in psychiatric care. This is being accomplished through a study of the curriculum in selected nursing programs, including the goals, methods, content, and learning experiences in the basic courses in psychiatric nursing and their adequacy in terms of present-day trends; through the formulation of objectives and the selection of content and learning experiences in psychiatric-mental health nursing; and through implementation of the above in the teaching of psychiatric-mental health nursing in the participating programs. Guides and resource materials will be published to be used in the development of course offerings and educational resources in psychiatric nursing in preservice nursing programs.

References

1. Action for Mental Health. New York, Basic Books, 1961, p. 252.
2. National League for Nursing. State-Approved Schools of Nursing--R.N. New York, the League, 1967, p. 106.
3. Ernest S. Long. Determinants of Career Choice in Psychiatric Nursing. Cleveland, Mental Health Manpower Office, 1958, p. 170.
4. George W. Albee. Mental Health Manpower Trends. New York, Basic Books, 1959, p. 180.

PROGRESS REPORT ON THE PROJECT

Joan E. Walsh

The purpose and goals as well as a brief overview of the project plan have already been described. The past and present activities of the project can be divided into the following three phases: (1) curriculum study, (2) content selection, and (3) curriculum implementation.

Curriculum Study

Initially, a survey was made of 10 diploma and 10 associate degree programs located in 16 states. From the information, some indication was obtained of the existing patterns of the course in psychiatric nursing in the two types of programs.

On the basis of previously established criteria, eight diploma and eight associate degree educational programs in nursing were selected to participate in the project. A questionnaire was devised and sent to the directors of each of these programs for the purpose of gathering information related to the total curriculum and the course in psychiatric nursing. Follow-up visits to each program were made by staff in order to gather further information that could not be ascertained by the questionnaire method.

Content Selection

The next phase of the project was selection of content and learning experiences appropriate for the two types of programs in light of present-day trends. In planning for this phase, the project staff was cognizant of the statements on technical nursing practice made in the ANA position paper on educational preparation for nurse practitioners[1] and of the descriptions of levels of psychiatric nursing practice given in the developmental statement on psychiatric nursing by the ANA Conference Group on Psychiatric Nursing Practice.[2]

Since one cannot plan for the course in nursing care of the mentally ill without considering the over-all program objectives and the content and learning experiences in the psychosocial aspects of patient care in all other courses in the curriculum, the staff was equally concerned with the integration of psychiatric-mental health nursing content in the total curriculum.

The trends in psychiatric nursing that were considered are: (1) the nurse working with groups of patients as well as with individual patients; (2) her consideration of the ward environment and her utilization of the nursing team when planning for patient care; and (3) her role in community mental health centers.

The method of approach for content selection, as seen by the project staff, is to state expected competencies related to the emotional-social aspects of patient care for technical-level nursing education programs in general nursing and nursing care of the mentally ill. The next step is to break down the competencies into objectives for the

different levels or semesters in the curriculum. Content and learning experiences can then be planned for the courses so that progression of learning in depth can occur.

Within the project, expected competencies have been stated, and related content has been selected and organized. Direction for the development of competencies was provided when the project staff met with a group of instructors from diploma programs representing the different clinical areas. An additional meeting was held with a similar group from associate degree programs. The areas of competencies selected and developed were (1) the nurse-patient relationship, (2) working with groups, including groups of patients, the nursing team, and the interdisciplinary team, (3) the therapeutic environment, and (4) terminal expected competencies in the general practice of nursing.

Two workshop meetings were held with a group of consultants representing various settings of psychiatric nursing practice and different levels of education for psychiatric nursing. The purpose of these workshops was to identify the theories and the concepts that would form a base for the selection of content in psychiatric-mental health nursing for integration in the curriculum and for the course in nursing care of the mentally ill for technical-level nursing education programs.

In order to plan for progression in depth and sequence, content was organized according to that preceding the course or unit in nursing care of the mentally ill, the course or unit in nursing care of the mentally ill, and the subsequent nursing courses. Taking the expected competencies into consideration, objectives were stated and content for each level was listed as knowledges, skills and abilities, and attitudes and appreciations in the broad areas of individual behavior, communications, and environmental influences. Learning experiences and evaluation methods were planned concurrently.

Curriculum Implementation

It is with the third phase of the project that we are currently involved. The participating programs, as they agreed at the beginning of the project, are to serve as demonstration centers--i.e., to try out the proposed method for planning integration of psychiatric-mental health nursing content throughout the curriculum and planning the course in nursing care of the mentally ill. The project plan and activities for this phase are as follows.

1. Mimeographed material was sent to the directors of the participating programs for their information, review, and comments. In this material the method of planning for integration and for the course in nursing care of the mentally ill was described in some detail.

2. A set of questions was sent to the programs for faculty discussion. The questions were designed to prepare the faculty representatives for the activities planned for this workshop.

3. The workshop itself is part of the third phase of the project. Its purpose is to help prepare faculty representatives to utilize the project method of planning for the integration of psychiatric-mental health nursing content and for the course in nursing care of the mentally ill. This preparation will include (a) determining for each program expected competencies relative to individual behavior and the nurse-patient relationship and the nurse working with

groups; (b) planning for progression of related content and learning experiences; and (c) planning for utilization of the competencies and inclusion of the content in the curriculums.

4. As a follow-up on the workshop, project staff will visit each program on a consultative basis in order to assist faculties in the utilization of their stated competencies and content organization. Additional resource materials will be provided--i.e., definitions of terms and the statements of expected competencies developed within the project.

5. In the spring of 1967, the faculties of participating programs will be asked to submit to the project staff statements of their expected competencies and content organization and their comments on the resource material.

Future plans for the project include an evaluation of the method of planning for integration and the preparation of the project materials for publication as guides and resource materials.*

*Subsequent to the workshop, two articles about the project were published. The first, "Teaching Psychiatric Nursing in Diploma and Associate Degree Programs," by Joan E. Walsh, appeared in the June 1967 issue of Nursing Outlook; the second, "Expected Competencies as a Basis for Selecting Content in Psychiatric Nursing," by Joan E. Walsh and Cecelia A. Monat, was published in the July 1967 issue.

References

1. American Nurses' Association. Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper. New York, the Association, 1965.
2. ———. Conference Group on Psychiatric Nursing Practice. Psychiatric Nursing--A Developmental Statement for Study and Reaction. New York, the Association, Mar. 1966.

INTEGRATION OF PSYCHIATRIC-MENTAL HEALTH NURSING CONTENT IN A CURRICULUM

Mona Moughton

When I actually took up my pencil to begin writing this paper, I found that in spite of my best efforts I truly had no succinct, erudite definition of the term "integration." Furthermore, I decided that I must have been affected by the heat this summer to have agreed to try to expound on the subject, but having made the agreement, I shall try.

I am sure you have each come to terms, in some fashion, with what integration of mental health and psychiatric nursing principles means and have some notions about how this meaning can be implemented. What do I mean by that term? When you get to the very, very bottom, it is quite simple. It just means that you help students to understand their patients, so that this understanding can in turn be used to facilitate nurse-patient communication in meeting needs of sick persons and their families. That is a very simple idea and one of the basic truths in nursing. However, there seem to be no rules ensuring that basic truths will also be easy to implement--and this one is by no means easy. As you must know, in the last 12 years, studies have been done and books have been written about integrating these principles into the basic nursing curriculum. Having read a number of them, I can still say that we have no formula--I cannot give you a list of 5, or even 50, things which, if you follow them faithfully one after the other, will ensure your accomplishing the task called integration.

Am I saying that integration of psychiatric nursing principles is not possible? Of course not. What I am saying is that we have a tough job, and I believe it is best to take an honest look at the task at the beginning and then make plans that are, hopefully, based in reality. There are many satisfactions, too. One of the greatest of these occurs when a student who has been truly struggling to get what you are driving at gets it. She has a satisfying, insightful experience with a patient and the world is all suddenly shiny bright.

Have you pondered much on why integration might be difficult in nursing? Two among the many possible reasons stand out. First, we hesitate to pry, but we seem to have problems in determining what is prying and what is helpful. The communication problem is great in nurse-patient interactions. The patient needs too much and is fearful of asking the busy nurse, and the nurse, whose potential is so great in relation to what the patient needs, is afraid to pry.

Secondly, integration from its beginning was associated with psychiatric nursing. The changes in psychiatric care during and after World War II started it all. Those of us in psychiatric nursing found we had mostly just ourselves to use in working with patients who were no longer secluded wholesale. However, as people, we are still rather wary of persons who get themselves labeled psychiatric. Rejection of these people has

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been standard procedure, even to the recent past, and has not improved greatly even yet. This rejection of the person labeled psychiatric was automatically extended to the people who cared for him. So what could this out-group possibly have to teach? There is always the niggling little concern, apparently, that some of the disturbed behavior might rub off, or something.

Integration in our terms also has overtones, or maybe undertones, of the larger problem of integration that in its entirety involves all minority groups not enjoying full citizenship rights. It is true that in this country, and particularly these days, we think of Negroes, but of course they are not the only minority group. Others are American Indians, psychiatric patients, tuberculosis patients, recovered drug addicts, and, in some ways, women. I recently attended a weekend meeting that included a well-planned civil rights program. I was quite literally horrified to hear one young man pleading for dignity and equality for the Negro and denigrating the psychiatric patients in the local hospital where he worked by calling them "crazy-heads," "nuts," and "the insane," and referring to their residing in a "looney-bin." My digression was deliberate. The dichotomous kind of thinking shown by that young man is representative of what most integrators hear at one time or another. The principles to be integrated sit over there somewhere; they are available "when we need them" or "when we have time we know where they are." Needless to say, that is not integration.

Then there is the confusion that seems to persist about interpersonal relations and psychiatric nursing. Much too frequently they are thought to be synonymous. As a teacher of psychiatric nursing, I might be told that Mary Smith would truly have benefited from an early rotation into the psychiatric unit because her interpersonal skills were so limited. But that student would have had just as much trouble in the psychiatric rotation as in any other, because psychiatric nursing is not the place to gain interpersonal skills; this is the area in which you sharpen those skills in relation to distorted thinking and disturbed behavior. Interpersonal skills underlie all of nursing, and indeed, all of life. No matter what you teach in a school of nursing, you also teach interpersonal skills. If you do it in no other way, you do it by example.

From what was just said I hope it is clear that, in my view, integrating psychiatric-mental health principles throughout the curriculum does not remove the obligation to include an experience with patients in a psychiatric setting, with appropriate content. I wish to stress that, although nurses in a psychiatric setting use interpersonal skills as do all nurses, the focus in psychiatric nursing is on the therapeutic use of self in relation to disturbed behavior and distorted thinking.

This generates another thought. The experience with patients in a psychiatric setting is best placed late in the total student experience. This is necessary because the student needs a good working knowledge of what people are like when they are well and what people are like when they are physically ill without the psychiatric label attached. With this experience, plus theoretical principles gained from the behavioral sciences--psychology, sociology, anthropology--as well as knowledge of normal growth and development, the student will have at least a working base from which to operate when attempting to understand and work with deviant patterns of behavior. In short, you can't know how sick a person is until you know how well he can be.

One of the most difficult tasks any one of us can take on is the attempt at self-awareness. We have said for years that you must be aware of your own needs and limitations before you can understand those of others and that you must understand the patient before you can meet the needs of the whole patient. Essentially, those statements are quite true.

If at least part of the time, you have been willing to face your own anger, hostility, anxiety, and frustration, you have experienced feelings that are not strange to you when you see them in patients--or students. Then you can attempt to empathize with what is happening with the patient or the student, and empathy will help you in assisting the student to make plans for working with patients. You will note that I am assuming that the emotional needs of the patient are the ones that will cause the difficulty. If the emotional needs of the patient are great and threaten the nurse, they may interfere with meeting the physical needs of the patient. After all, nursing care takes place in an interpersonal situation.

There is much fuss these days about the nurse's having left the bedside. It is said that physical contact with the patient is avoided, and that those of us who teach are fostering this. If the nurse is not found at the bedside, I wonder if the patient's need for interpersonal contact is not more responsible than any real avoidance of physical nursing care. The average patient these days is not sick, truly sick, for very long. The amount of concentrated effort required of the nurse is often limited, which leaves lots of time for talking. If we have allowed students to feel inadequate and shun situations that call for interpersonal contact, then we have much work to do.

Integration is on-the-job learning, because you have to be there to get the benefit. It involves feelings in a way that words on a page cannot impart. If the student is to learn to recognize, accept, and, when possible, use these feelings, supervision is essential. I have found that pre- and post-conferences, process recordings, and nursing care plans were my most important tools in teaching, both in the course in psychiatric nursing and in other clinical courses. I learned early that resources, whether things or people, can be a nuisance. The doctors who lectured rarely understood the level of the students they were addressing, which meant that I had to take precious time to clarify what they had said. It was easier and more effective to do it myself in the first place. I found that the actual nurse-patient situations in which students found themselves were far more useful than films in illustrating theory. There are some films that are quite good, but why use a substitute when you have the real thing? It has been years since I've used any film except "Psychiatric Nursing: The Nurse-Patient Relationship."[1]

I should like to add a few words here in support of process recording. The examination of the interpersonal process is essential. It is time-consuming, it is painful, it is resisted, but nothing I know of can substitute for it. The nurse must attempt to understand her own behavior and its impact on the patient as well as the impact of the patient's behavior on her. It is here that problems arise in relation to prying, identification, and overinvolvement. Nondirectivity works well to prevent one from prying, which of course is possible. Through reflective statements, the nurse indicates her interest, her willingness to listen, but only at the patient's pace and only as much as the patient is able to express verbally. The nurse deals only with conscious material and conscious motivation. The deep-seated unconscious motivations, whatever they may be, are best left to a more skilled guide. Students who are new to nursing, who are sensitive and have a strong need to help, frequently identify with the patient and his problems, at which point the student can no longer be of help. "Involvement" isn't a term about which I concern myself. If I'm going to be of help to someone, I must get involved. However, if I'm to be of help, I must not identify--to me the so-called problem of involvement is really the problem of identification. One of the ways that I have found useful in handling this identification-involvement situation is in working with the student to sort out what the problems are in the situation and to whom they belong.

It is just about at this point that someone begins to worry that the integrator will assume the role of therapist. The line between learning and therapy is pretty fine. One can learn through therapy, but the focus of the interaction is therapy. Learning may be therapeutic through a corrective process, but the focus is learning, not therapy. In nursing, the learning focus is to give complete nursing care. The integrator must keep the focus clear.

Nor is integration an activity of only the integrator. It is a collaborative effort, as is the teaching-learning process. Expecting this person labeled integrator to come along and put pretty patches here and there on the program is useless. The ultimate object of the whole effort is to meld the requisite principles into the fabric of the program in such a way that they are a part of the way everyone functions every day with everyone.

Providing a therapeutic interpersonal experience for a patient is a task requiring thought and skill, particularly these days when the relationship may be relatively short-term. The brevity of the experience absolves no one, however; it just means that effort must be concentrated.

Man in relating to others most apparently uses communication, which may be verbal or nonverbal. Communication requires that you be a good listener. A good listener is a person skilled in the understanding of interpersonal relationships and in the art of creating an atmosphere in which people can work through their own difficulties. We do not solve very many problems for anyone; we help them to solve their own problems.

One of the most important therapeutic measures a nurse can use is her ability to listen. It is a rare and difficult art. In order to be a good listener, one must overcome the tendency to burst into speech in response to everything one sees or hears. All too often we are only waiting for the other person to stop talking so that we can start again; sometimes we don't even wait for them to stop.

Worse still is the tendency most of us have to interfere or interrupt when something is said that we do not want to hear. At such points, we tend to take over, to steer away from the subject, and we usually do it so smoothly that we ourselves are not aware of what we are doing.

No one can talk with a patient and completely avoid relating to oneself and one's own family what the patient says. Some of these thoughts will be so painful that listening becomes nearly impossible. Even though we are nurses, we are human beings. However, if what is happening is recognized, it will be easier (not easy) to detach my feelings from your problem. As one student told me, "It takes courage to stay and listen." It does, but if you want to learn something or if you want to be helpful, you must be prepared to listen. The patient cannot talk while the nurse is talking.

I said that with awareness, it would be easier to detach my feelings from your problem. I want to pull that sentence out and emphasize it. Remember that no matter how you feel about the problem being discussed and no matter how you would solve the problem if it were your problem, it is not your problem. If you are in a discussion of a problem with a patient, it is your obligation to help him think through to a solution of his problem, and that is your problem in this situation.

Part of listening is looking alive, being responsive--verbally responsive if this seems indicated. Telling one's troubles to an interested, sympathetic, uncritical person can be very reassuring. "I am a person who counts. I must have some worth because another person took the time to hear me out." In psychiatric nursing, this "talking it out" may very well be a substitute for "acting it out."

This tendency to assume unto ourselves responsibility for problems that are not ours seems to be quite common among nurses. I suppose it goes along with our image of ourselves as helping persons, but in instances of this sort, we are overstepping the limits. As teachers and as integrators, you may very well find yourselves having this same problem. If you can step back from the situation for a moment and ask, "Now whose problem is this?" it may help. I had a student call me one evening in great distress because her patient said he was in love with her. I asked her if she was in love with him, and she said No. So I said, "Then this seems to be the patient's problem, doesn't it?" She and I both had problems over this, but our problems involved the quantity and quality of her relationship with him, not love. This man had a depressive illness, and at the time the student chose to work with him in a one-to-one interaction, he was quite sick. She was a very capable student and had worked quite well with this patient. In sorting all this out, our conclusion was that the patient understood how much the student had done for him and was grateful. However, he had identified the feeling of gratitude as love.

Communication also includes the use of questions. One cannot get a clear answer to a vague question. If the question is stated precisely, the means of answering it are clearly indicated. The individual who suffers from personality maladjustment is known to all as a person who above everything else wants answers. He persistently stumps himself, with resulting ulcers, or whatever. He is anxious, the questions he asks to get some explanation for this discomfort are vague, the tension mounts, the questions get fuzzier, and on it goes in a cyclical fashion. Therapy often is the tool needed to help him state a clear question so that he can recognize the answer when he sees it. Quite often he had the answer all the time--the question obscured that fact from him.

There are certain words that tend to make for confusing, unanswerable questions. The words are harmless unless we use them to ask vaguely abstract questions. These words, among others, are "should," "ought," "why," "right," "wrong," and all the "is" questions. "Why did this have to happen to me?" "What causes fear?" "Am I a failure?" These questions are stated in unlimited terms, and therefore there is no possible way of knowing whether any particular answer would be valid or even relevant.

What these people need are new questions--new in the sense that the old questions need restating. Even this, though, can be difficult because the anxious person seeking an answer to his question is unlikely to easily appreciate that his question as stated is unanswerable. He just wants an answer, and preferably an absolute answer. This can pose a challenge in any nursing situation. I remember being asked by a woman who had just learned that she had multiple sclerosis, "What have I done to deserve this? Why did this have to happen to me?" In my verbal armory, there is no set of words that would answer either of those questions. However, I assumed that she was still having difficulty accepting that diagnosis, so what I did say was, "You wish this hadn't happened to you. But it did happen to you, and right now you are miserable." That most likely wasn't related to the questions she had asked, but she started to cry and then asked, "But what am I going to do?" Now we had a question.

Anxiety is the chief handicap to communication. Anxiety is unpleasant but apparently inevitable and can be made an ally if it is understood. Anger, of course, is one of the commonest masking operations of anxiety. Far too often the anxious nurse or the anxious patient uses anger as a tension-reducing device rather than using this energy to understand whatever seems to be creating the difficulty at the moment.

Man in relation to the environment was a concept that had little real meaning back in my early days in nursing. We mostly related our nurse image to the hospital, and there were few who tried to disabuse us of this. There were a few public health nurses, industrial nurses, and school nurses, but their jobs were really quite different and out of the ordinary. How different things have become. Now we prefer to keep people at home, particularly children, if it seems possible. In psychiatry, the tendency is to send people with depressive illness home as soon as it seems feasible, so that the person associates his returning health, energy, and joy of life with his home and family rather than with the hospital. Since the publication of Action for Mental Health,[2] we seem to be making hesitant progress, but progress, toward small mental hospitals, community mental health centers, day hospitals, night hospitals, halfway houses, and psychiatric units in general hospitals. The object again is to keep the patient as near to his home as possible, or in the case of the day hospitals, at home for part of the 24-hour period. In this way we do not see the massive apathetic withdrawal of people who are cut off from family and friends; it would seem that people may be getting to these units before the deviant patterns have become well established. Families are learning that although this illness, like most illnesses, can be devastating both financially and emotionally, it, too, can be weathered with help.

Who helps? A great many of the people who will help are the students we are teaching, those who will soon be graduates, and the graduates of the future. These are the nurses who as yet don't know what can't be done. If we teach them well, they may show us that what we thought impossible can be done. If we give a student a formula for each problem but no skill in working out formulas for herself, we have turned out another robot. We have too many of them already in nursing. Help the students to identify problems, ask answerable questions, but don't give them pre-mixed answers. Teaching in this manner is difficult--it is called education for uncertainty. With a world of computers coming up, what will the nurse be asked to do 10 years from now?

I wonder how many of you, particularly those of you who teach, have been asked if you miss doing "real" nursing. How many of you who are psychiatric nurses have been asked when you last did nursing? I've been asked both those questions quite recently. What do these questions say about the popular image of the nurse? We have not yet done a very good job of explaining to people about nursing, but I am mostly concerned about our present and future students, the nurses of the future. The imaginative and creative ways that these nurses will use in working with patients, their families, and their communities could very well be cut off by such shortsightedness.

If these future nurses are to help, they will need much support and guidance from people like you and me They will need massive amounts of support to attack areas of health needs in the face of the criticism that they aren't doing real nursing. I'm reminded of an experience that a few students had with the VNA in one town where I taught. As part of their psychiatric experience, these students visited, usually weekly, one family on the VNA roster whose problems were considered emotional or interpersonal. These families were rarely seen by the VNA staff because of the press of physically ill patients. These students, with their talking visits, as they called them, accomplished a great deal, some almost miracles. We had one student who visited a family in which there were two adopted children. The mother was 49 and the father in his early 50's. They had had no children of their own. They had a boy of 7 who was in school, and a girl of almost 2. These older parents had been able to adopt such young children because it was an internal family arrangement. The problem as understood by the VNA

staff was that the boy was having behavior problems in school, but this probably reflected the extreme difficulty everyone in the family was having with the daughter. She was not toilet-trained, she had eating and sleeping disturbances, and the mother felt that her daughter hated her. The student came back from her visit to the home and said, "I don't believe that mother knows much about children." Using this as a hypothesis, the student organized a short course in growth and development, stressing the expected behaviors at certain ages and stages, and taught these parents. It worked; it was like magic. Can't you just hear some people say, "But that's not nursing"? I might add that we did screen both the students and the families rather carefully. We did not use a family that the agency had not visited. Also, the public health nurse from the agency accompanied the student on her first visit. We had to discontinue this because of the lack of supervision, but if any of you are in a position to do something like this, I certainly recommend it.

As yet, I haven't sorted out and pointed out these mental health principles we are integrating. I find I prefer, in general at least, the four principles identified in the integration project at the University of Colorado School of Nursing in Denver.[3] Briefly, these are self-awareness, communication, problem-solving applied to the nurse-patient interaction, and freedom to try new skills in situations with guidance and without blame. These could be multiplied, but what we truly want is a nurse who understands human behavior and isn't afraid to work with it. Each part of the universe acts on and is acted upon by every other part. Since we therefore must have some kind of an effect on our environment, I'm in favor of exploiting the environment in any way possible. I believe that the only nurse who can survive in the future is the nurse who understands herself--her abilities and her limitations, who uses what she knows and what she is in her problem-solving interactions with patients and others, and who has been encouraged and supported while she tried to solve old problems in new ways. The problem for our generation--the teacher generation--is to ensure the future survival of these nurses and nursing.

References

1. Psychiatric Nursing: The Nurse-Patient Relationship (34 minutes). ANA-NLN Film Library.
2. Action for Mental Health. New York, Basic Books, 1961.
3. Report of the University of Colorado School of Nursing Experience in the Integration of Mental Hygiene Concepts in the Basic Collegiate Program. Prepared by the Bureau of Nursing Research and Studies, University of Colorado School of Nursing, Denver, Colorado, 1960.

WORKSHOP PLANS AND INSTRUCTIONS FOR PARTICIPANTS

Joan E. Walsh

The purpose of the workshop is to prepare faculties of the participating programs for implementation of the project method of planning for integration of psychiatric-mental health content in their curriculums and for the course or unit in nursing care of the mentally ill. The workshop task for participants is to develop expected competencies in the psychiatric-mental health nursing area for their programs and then to list and organize related content, learning experiences, and evaluation methods. At the end of the workshop, participants will share with the group their plans for incorporation in their curriculums of the competencies that they have developed for their programs. In doing so, they will indicate any problems that they expect to encounter in implementing their plans.

Participants are asked to complete a form for evaluation of the workshop. /See Appendix B. Section 5./ The evaluation form calls for a written account of the faculty representatives' plans, including anticipated problems, and asks that they make suggestions as to how the project staff, at the time of their follow-up visits, can be most helpful to their faculties in the implementation of their plans.

For the purposes of the workshop, the expected competencies and areas of psychiatric-mental health nursing content have been divided as follows:

1. The nurse-patient relationship and individual behavior.
2. Working with groups (listed as group process on the agenda).
3. The therapeutic environment.

Participants are asked to work on the nurse-patient relationship and individual behavior initially. The first step is to consider the philosophy and objectives of their program and then to state in behavioral terms the competencies expected of their students in the nurse-patient relationship at the completion of the program. Then, using the worksheets, participants are to plan the content, the learning experiences, and the evaluation methods related to the nurse-patient relationship, including individual behavior, that are to be integrated into their curriculums.

The worksheets should indicate how the content progresses sequentially in depth throughout the curriculum. The content should be divided and stated as knowledges, skills and abilities, and attitudes and appreciations. Content that precedes and follows the course in nursing care of the mentally ill should be indicated as well as the content for the course itself. The worksheets are the same as those used by the faculties in tracing an area of content throughout their curriculums in response to certain of the questions for faculty discussion that were sent to them this summer as preparation for the workshop.

Later in the week, working with groups will be considered. The assignment will be the same: (1) to state in behavioral terms competencies expected of students at the

completion of the program and (2) to develop on the worksheets the related content, learning experiences, and evaluation methods that are to be included in the curriculum, showing progression as before.

Resource people are available for assistance. Participants may work with faculty from other programs at their table or they may work individually. Each group has been provided with the project definitions of terms for their information.

INDIVIDUAL BEHAVIOR AND THE NURSE-PATIENT RELATIONSHIP

Cecelia A. Monat

I am sure no one here today was surprised to see the content area of individual behavior and nurse-patient relationship included on the agenda. For many years nurse educators have agreed that this content is an essential part of any program of basic nursing education. However, while few would dispute the necessity for its inclusion, many faculties are dissatisfied with their efforts in this area.

Perhaps if we briefly look at the reasons justifying the inclusion of this content, it may give us some clues as to its implementation. As in planning any area of content, it is necessary to begin by examining the desired end, i.e., the expected competencies of the student immediately prior to graduation. What is it we expect this student to be able to do as a result of her education? To the best of my knowledge, all programs in basic nursing education purport to prepare "beginning first-level practitioners in nursing." What this statement means, however, differs, sometimes markedly, from school to school and from program to program. If the statement means that the graduate is prepared to render what we call "total" nursing care to individual patients, then she must, of necessity, have background knowledge of, and experience in dealing with, individual human behavior. Patients, by virtue of their humanness, engage in behavior. This is significant to the nurse because observation of the patient's behavior is frequently her only means of inferring what the patient is feeling, thinking, et cetera. Is it important for the nurse to have clues as to what the patient is thinking and feeling or is it an intrusion into the privacy of the individual? We believe it is important and relevant to nursing care, because we know as a fact that the mind and body are inextricably related --that whatever affects one will affect the other. We also know that inherent in all illnesses and/or hospitalization is a greater or lesser degree of psychological or emotional disequilibrium, if for no other reason than the fact that the patient's normal routine has been disrupted.

That which has been said so far applies to all people, including the patient and the nurse, well or ill. Now what about the mentally ill? We know that diagnosed mental illness is a behavioral manifestation of disturbed thoughts and feelings. We say we are preparing students to give nursing care to these patients as well as to the physically ill. If we agree that learning takes place best when it proceeds from the simple to the complex, from the normal to the abnormal, from the obvious to the subtle, then we can see why the student needs foundational knowledge of and experience with normal individual behavior if she is to proceed to the study of abnormal or exaggerated forms of behavior.

Until now I have been speaking solely of the justification for inclusion of content relative to individual behavior. However, in nursing, the purpose of our including this content is to provide the student with a foundation upon which she can build a body of knowledge

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and skills pertaining to the relating process in which the nurse engages. Content about the relating process is unique to the occupation of nursing and is that which we, as nurse educators, teach. We really have no choice as to whether or not the student will learn anything about the relating process in nursing. If we accept the fact that she needs to have knowledge about individual human behavior and if we use the clinical laboratory as one of the related (concurrent or coordinated) learning activities, we are automatically introducing the student into a "relating process" with the patient. Therefore, our only choice is whether our graduates are going to engage in this process knowledgeably or intuitively. In other words, our one choice is whether or not we are going to teach anything about the relating process in nursing; students will learn many things about it whether we teach anything about it or not.

It is important for nurse educators to include in their curriculums content and learning experiences about the different aspects of the relating process because of the potential therapeutic value that the nurse has when relating with patients. This element of nursing care is not an "expendable" luxury, but rather is inextricably interwoven with all the activities of the nurse. In fact, there are some who believe that the nurse-patient relating process is the essence, or core, of what is called nursing care. This belief is supported by the fact that we know that a consistent, significant person in the patient's environment can have a profound effect on the patient's behavior. This, in turn, has the potential of positively (or negatively) affecting the patient's physical health. These facts are most observably demonstrated by the mentally ill patient and the patient whose physical illness has an emotional etiology, but they will hold true for all patients to a greater or lesser degree.

As we all know, the health worker who has the most continual contact with the patient, and therefore the greatest opportunity for observation and intervention, is the nurse. Therefore, the importance of her having knowledge and skills pertaining to the relating process is great.

Now, let us assume that we accept the necessity for the inclusion of these content areas--individual behavior and the nurse-patient relationship--in our curriculums in basic nursing education. What specific content do we teach? When do we teach it? Where?

The answers to these questions lie within the philosophy and the objectives of the particular program and in the competencies expected of the students at the completion of their education. As I have said, all programs in basic nursing education state in one way or another the intention of preparing their graduates for beginning first-level practice in nursing care of patients with major health problems. The important question now is whether or not the faculty agrees that this statement applies equally to the nursing care of the mentally ill. Many faculties are in disagreement about this for a variety of reasons, which we need not go into here. The direction this statement will give regarding inclusion of content will obviously be dependent upon its meaning. In other words, the content will take one focus if beginning first-level practice in nursing does not include nursing care of the mentally ill, and another focus if it does. The project staff believes, however, that through understanding and familiarity with content appropriate to this level, faculties will develop a deep commitment to the belief that students at the technical level can and should be prepared to give beginning first-level nursing care to the mentally ill as well as to the physically ill. The remainder of what I have to say is predicated upon this belief.

The inclusion of content relative to individual behavior and the nurse-patient relationship should be reflected in the philosophy and the objectives of the program. After termi-

nal expected competencies are developed, expected competencies should be stated for each level in the student's development, and these also should include and reflect the content areas of individual behavior and the nurse-patient relationship.

Traditionally, the aspect of nursing care that deals with patients' feelings and behavior has been called psychiatric-mental health nursing--probably only because it was those nurses who were trained in psychiatric nursing who first saw the relationship between behavior and illness as applied to the theory and practice of nursing. Whatever you wish to call it--mental health content, psychiatric-mental health content, or general nursing content--it should be included in all courses that are concerned with patient care. Therefore, this content will be reflected in the objectives and/or competencies for each course.

The study of individual behavior traditionally belongs to the discipline of psychology. Individual human behavior, as such, cannot be readily studied in a nursing context, since students either observe or interact with patients as part of their learning experience, and as soon as they do so, another variable is introduced into the situation--namely, the student herself. Then, what is it that we teach in nursing courses? We teach the "relating process" by helping the student to transfer and apply knowledge about individual human behavior from the psychosocial sciences to what we choose to call the nurse-patient relationship. Of course, this assumes that the course content in the psychosocial sciences includes the study of the behavior that falls into the range of what has been designated as "normal."

Since behavior has varying degrees of complexity in relation to its etiology and manifestations, the project staff believes that students can and should be introduced to the study of behavior in its most simple and obvious form and progress to the most complex and subtle form, i.e., mental illness. Concurrent with the study of behavior is the study of the relating process, since, as I have already stated, individual human behavior cannot be studied in isolation in a nursing care context.

For the purposes of this project, three types of relating in which the nurse functioning at the technical level may engage have been differentiated and delimited. They are as follows.

1. Nurse-Patient Interaction

> The purposeful, planned behavior of the nurse that has an effect or influence on the patient and that, in turn, is affected or influenced by the patient's response. Therefore, the nurse-patient interaction is a dynamic two-way process. The behaviors of the nurse and the patient combine to bring about mutual, although not necessarily similar, changes in the thoughts, feelings, and behaviors of the two persons involved.[1]

2. Nurse-Patient Relationship[2]

> An interaction process necessarily involving the nurse and the patient in fairly prolonged contact over a period of time. The nurse offers a series of purposeful activities and practices based on a body of theoretical and empirical knowledge, with the goal of fostering the patient's physical, social, and emotional well-being. This relationship differs from a social relationship, in which two persons interact primarily for reasons of pleasure or companionship, with neither person in a position of responsibility for helping the other.
>
> The nurse-patient relationship takes place in the daily living situation in which

the nurse and the patient find themselves and is consistent with the over-all treatment goal for the patient determined by the interdisciplinary team. It is not an end in itself, but rather a means through which (1) other aspects of nursing care are facilitated and can be made more effective and (2) the patient experiences a meaningful, healthy, satisfying interpersonal relationship, to the end that he may be able to transfer that which he has learned from this relationship to his relationships with others.

The goals of the nurse in a nurse-patient relationship are based on the needs of the patient and are designed to provide opportunities that will help the patient to grow emotionally. They include helping the patient to (1) maintain himself biologically; (2) identify, state, and meet his specific and concrete needs whenever possible; (3) clarify his feelings; (4) participate with others; (5) communicate with others; (6) increase his self-esteem; (7) increase his comfort and minimize his anxiety; and (8) test reality.

The nurse helps the patient to achieve these goals through the use of both verbal and nonverbal communication and by employing the following purposeful and planned attitudes and activities based on her knowledges and abilities: acceptance, respect, sensitivity, support, reassurance, encouragement, empathy, understanding, limit-setting, and consistency. The nurse deals only with conscious material and does not make dynamic interpretations of meaning to the patient. She focuses on strengthening areas of health. Emphasis is placed on current problems of the patient's living with others in the ward setting. The manner in which and the degree to which these attitudes and practices are implemented and manifested are determined to a great extent by the nurse's own unique personality and the degree of her self-understanding, self-acceptance, and educational preparation.

The nurse-patient relationship is artificially divided into three phases of development. In reality, these phases cannot be isolated, but tend to overlap.

The first phase is initiating the relationship. This phase is centered upon mutual attempts to know each other and to help the patient become oriented to his environment. The commencement of this phase is the responsibility and the function of the nurse, although in some instances the patient may take the initiative. Establishment of the foundations of acceptance and mutual trust is the predominant feature of this phase.

The second phase is continuing the relationship. The focus of this phase is on helping the patient to benefit from the interaction through the use of the attitudes, the activities, and the practices stated above.

The third phase is concluding or terminating the relationship. This phase is concerned with helping the patient to transfer his healthy modes of interaction from the nurse to others in his social milieu, both within and outside the hospital.

The nurse is supervised in this relationship, preferably by an experienced nurse with professional preparation.

3. Nursing Intervention

The purposeful, individualized, planned activity of the nurse, designed to help the patient regain psychophysiological homeostasis in a specific crisis situation associated with his illness. This crisis situation is a result of a psychophysiological disequilibrium caused by either internal or external forces with which the patient cannot cope unaided.

> In psychiatric nursing, nursing intervention--the purposeful, individualized, planned activity of the nurse--is designed to help the patient deal with an increase in anxiety engendered by a specific crisis situation associated with his illness. This crisis situation can be a result of either increased intrapsychic conflicts or environmental forces with which the patient cannot cope unaided.

We see the nurse at this level in any setting having a relationship with a few selected patients, interacting with many patients, and intervening with all patients as is necessary. Nursing interaction and the nurse-patient relationship are part of the nursing care plan for the patient, which is, in turn, part of the total over-all treatment plan.

Because of the relative depth and complexity of the nurse-patient relationship, the project staff believes that it can best be taught in the course or unit in nursing care of the mentally ill.

Content relative to nursing intervention and nursing interactions needs to be taught throughout the program, starting with the first clinical course. Competencies, course outlines, et cetera, should reflect this content and indicate levels of progression. In this way, the graduate who works in a general hospital setting will be prepared to fulfill her function of primary prevention and crisis intervention.

If we provide the student with the opportunity to learn and develop selected knowledges and skills relative to individual human behavior, nursing interaction, and nursing intervention prior to the course or unit in nursing care of the mentally ill, she will be prepared to study patient behavior and the nurse-patient relationship. As can be seen from the definition, at this depth the relating process is one in which contact with the same patient is maintained over a period of time and is focused on the here and now--i.e., on those situations and activities in which the patient and the nurse find themselves. The relationship is planned and purposeful and consistent with the over-all nursing care plan for the patient. The nurse's primary function is that of support; her major tool, her use of self.

The technical-level nurse engages in the nurse-patient relationship under the supervision of an experienced professional nurse. The instructor, of course, functions in this role for the student of nursing. How can the supervisory process best accomplish its purpose? The project staff believes that one method is through the use of process recordings, interaction notes, or whatever you wish to call the tool through which the student records what the patient said and did, what she herself said and did, and what she believes to be the meaning of the interaction. This tool can be introduced in a very simple way the first time the student has contact with a patient. If this is done, by the time the student reaches the course or unit in nursing care of the mentally ill she should be able to write a process recording with a fair degree of accuracy and completeness. The theory of abnormal, or deviant, behavior about which she will concurrently be learning will enable her to make hypotheses regarding the meaning of the patient's behavior at a greater depth than she had previously done. This is an example of what is meant by learning's progressing from the simple to the complex.

Inherent in the nurse-patient relationship is the necessity for the nurse to have a sufficient degree of awareness of her own behavior so that it does not impede the progress of the patient but, rather, fosters it. Let me emphasize, however, that as educators we are interested in the student's behavior only insofar as it affects the nursing care she renders. This information is obtained through our observations of her in the clinical laboratory and in a very concrete way through her process recordings. We can then see

the necessity of reviewing our observations and her process recordings with the student if she is to benefit from them. Ideally, this is done in planned, regular, individual conferences. Without such conferences, the mechanics of writing a process recording have relatively little value and, in fact, may help to reinforce nontherapeutic patterns of behavior on the part of the student.

The project staff also believes that the student-teacher relationship serves to a large extent as the prototype of the nurse-patient relationship. If the student has never experienced acceptance in her relationship with the instructor, how can she be expected to feel and behave in this way toward a patient? Therefore, the student-teacher conference also serves as a framework within which the student has the opportunity to experience many of the attitudes and feelings about which she is learning. However, I wish to stress once again that the focus and the goal of the student-teacher relationship in general, and the supervisory conferences specifically, are educational in nature as opposed to the nurse-patient relationship, where the focus and the goal are therapeutic in nature. To be sure, there is a thin line between education and therapy. Neither can be completely separate from the other. It is for this reason that we may frequently observe a student for whom the educational experience was truly therapeutic and a patient for whom the therapeutic experience was educational. Bear in mind, however, that if this should occur, it should be seen as a secondary outcome, with the student's growth in nursing knowledge and skill as the primary consideration. Because the situation is reversed in the nurse-patient relationship and because we were all nurses before we became educators, many nurse faculty may have an inordinate amount of difficulty differentiating between these roles.

Just as the clinical courses that preceded the course or unit in nursing care of the mentally ill included content and learning experiences in individual behavior and the nurse-patient relationship, so should the clinical courses that follow. This content and learning experience, once again, should be reflected in the competencies and/or objectives of succeeding courses and should show greater depth and progression of learning. Not to do this helps to make psychiatric nursing an isolated experience with limited value and applicability to other areas of nursing practice.

To reiterate: The course or unit in nursing care of the mentally ill should not provide a basis for knowledge about human behavior and skills in the relating process in which the nurse engages. This basis is found in all previous clinical courses and in the courses in the psychosocial sciences. The focus of the course or unit in nursing care of the mentally ill is on understanding abnormal, or deviant, behavior and appropriate nursing care. Subsequent clinical courses help the student to utilize greater understanding and skill in the nursing care of patients with multiple complex problems--both physical and emotional. Obviously, then, this is a "thread" which runs throughout the curriculum.

In order to insure the inclusion of threads of content, the entire faculty must work together in making careful specific plans as to what competencies are expected of the student at what level of her education, what content and learning experiences will be provided at each point in this progression, how these competencies will be evaluated, et cetera. As already stated, the competencies are, to some extent, determined by what content has preceded and what is to follow. In addition, they are stated behaviorally with enough specificity to give direction for evaluation. They should reflect the depth of knowledge and level of practice expected of the student at the time.

When the faculty works together in curriculum planning, much repetition and overlapping is avoided, since each instructor knows what content and learning experiences the

student has had and what she will have in subsequent courses. This elimination of needless repetition may very well provide a partial answer to the frequently expressed question, "How can I possibly teach all that the students need to know in the time allotted to me?"

This paper was designed to provide you with some over-all guidelines for your task of developing competencies, selecting content, planning learning experiences, et cetera, in relation to the content area of individual behavior and the nurse-patient relationship. Bear in mind that much more could be said about this topic alone but that the determination of specific competencies and content is the right and the responsibility of individual faculties.

Notably absent from this discussion is consideration of such content as group process, environmental influences, and the nurse as a team member. These topics will be considered in subsequent papers.

References

1. Libby Zagorin. "Identification of the Components in a Therapeutic Nurse-Patient Relationship, Part II," in Psychiatric Nursing Concepts and Basic Nursing Education. Proceedings of the Conference at Boulder, Colorado. New York, National League for Nursing, 1960, p. 102.
2. Joyce Samhammer Hays. "The Psychiatric Nurse as Sociotherapist." Amer. J. Nurs. 62:64-67, June 1962.

Charles K. Hofling, Madeleine M. Leininger, and Elizabeth Bregg. Basic Psychiatric Concepts in Nursing. Philadelphia, Lippincott, 1967, pp. 29-73.

Maurice Levine. "Principles of Psychiatric Treatment," in Franz Alexander and Helen Ross, eds. Dynamic Psychiatry. Chicago, Univ. of Chicago Press, 1952, pp. 307-366.

Carol A. Lindeman and Sister Edith Turberty. Integration of Human Relations Content in Baccalaureate Nursing. St. Paul, Minn., College of St. Catherine, Dept. of Nursing, 1965, p. 42.

Marguerite Lucy Manfreda. Psychiatric Nursing. Philadelphia, F. A. Davis, 1964, pp. 122-131.

Dorothy Mereness and Louis J. Karnosh. Essentials of Psychiatric Nursing. St. Louis, C. V. Mosby, 1966, pp. 38-46.

Morris S. Schwartz and Emmy Lanning Shockley. The Nurse and the Mental Patient. New York, Russell Sage Foundation, 1956, pp. 244-281.

Zagorin. Op. cit., pp. 106-111.

THE GROUP PROCESS

Cecelia A. Monat

One of the most important and, it seems,most neglected areas of content in programs of basic nursing education is the group process. For the purposes of the project, group process can be defined as the obvious, predictable interactions that take place among three or more persons in a specified situation.

There are at least three major underlying justifications for the inclusion of content and learning experiences relative to the group process in basic nursing education curriculums. First, the groups to which an individual belongs influence his behavior, and the nurse is vitally concerned with understanding behavior when giving care to the individual patient. Second, the nurse is frequently required to render nursing care to patients on a group basis for reasons of both time and labor economy and also for the therapeutic value of this approach in some situations. Third, comprehensive patient care is most expediently and effectively planned and carried out when nurses and members of other health disciplines function as a coordinated group. It therefore seems obvious that the student should have planned content and learning experiences related to the group process when we realize that a large part of her practice as a nurse will be concerned with groups of people. Unfortunately, though, most nurses at this point in time are not prepared in this and so function intuitively in the dynamics of group interaction.

Lip service is paid to the fact that everyone is a member of a family and that the family is the basic unit of society. However, as nurse educators we seem to ignore the fact that the family is a specialized group and that principles of group functioning are followed and can be observed as well here as in other types of groups.

The family, as we all know, is part of a larger group that is labeled "the community." Concurrently, individual members of the family may be members of many other subgroups or secondary groups within the community, such as schools, clubs, gangs, fraternal organizations, and religious groups, depending upon their needs and interests. This phenomenon occurs because man is by nature a gregarious being--that is, he has a very real, identifiable need to associate with and belong to groups of others who are like himself. In addition, we are living in a highly complex, technological society. No longer is it possible for a family, much less an individual, to survive (even in a physical sense) without relying on others for services. Therefore, the nature of our humanness and the nature of the society in which we live render us interdependent, i.e., force us to live within some type of group structure.

A person's association with groups changes as he progresses developmentally. The groups to which he belongs, either voluntarily or through circumstance, have a strong influence on how he thinks, feels, and behaves. Previously, we considered the need for the nurse to understand individual behavior and the nurse-patient relationship. Nurses cannot even begin to understand the behavior of the individual patient unless they consider the groups of which he is a member. Therefore, the understanding of individual behavior is enhanced by an understanding of the influences of groups on the person. Equally true is the converse: understanding of groups is facilitated by understanding of the be-

havior of people as individuals. Taken together, knowledge of both individual behavior and the group process enables the nurse better to view the patient as a whole, in the totality of his functioning.

In a homogeneous society, the nurse is not so aware of the need to consider the patient's group association, because it is very likely that she is a member of many of the same groups and subgroups to which the patient belongs and therefore shares with him a frame of reference. However, in a society that is as heterogeneous as ours, this does not necessarily hold true. For example, we are all familiar with the fact that in large urban areas, it is not only possible but very likely that neighbors do not know each other or have anything in common. In these instances, intuitive functioning on the nurse's part in regard to the patient's group associations is likely to be ineffective.

Above and beyond the necessity for having some knowledge of the group process in order to be better able to give quality nursing care to the individual patient, knowledge of the group process is necessary for the nurse because it is not possible for the nurse to give nursing care to one patient alone. She may not only be responsible for the care of 2, 10, 20, or more patients but may very well render aspects of this care to these patients as a group. To put it succinctly, the demand for nursing care far exceeds the supply of nurses. This is especially true in psychiatric nursing, but it holds true in almost all other clinical service settings as well. Even if the supply of nurses were adequate, there would still be some instances in which the group approach to nursing care would be the preferred approach. One example is the informal health teaching of a group of postpartum women. They might feel more comfortable in exposing their ignorance, superstitions, et cetera, among others who share similar ideas than they would if alone with the nurse, who may be perceived as a censorious authority figure. Helping patients to learn to interact and socialize with others is a primary function of the nurse who works with the mentally ill. Therefore, another instance in which nursing care is preferably rendered within a group situation is helping a withdrawn patient to learn to socialize with others.

One of the things frequently heard from new graduates is that they felt unprepared for their first positions. More often than not, one of the problems lies in the fact that they felt overwhelmed by the relatively large number of patients to whom they were assigned. The solution to this problem is not merely a matter of the student's needing more experience in organizing her work. Unless she has some understanding of and skill in dealing with groups of patients, an increase in her ability to organize will be of little value. Generally speaking, the pattern of nursing education is such that the student is taught to give nursing care to individual patients. There are many justifiable reasons for this approach to teaching. However, it is imperative that the student not graduate with the subliminal impression that she is an independent practitioner who is responsible for the nursing care of only one patient at any given time. It is possible and necessary to combine the positive aspects of learning on a one-patient-to-one-student basis with content and learning experiences relative to the student's working with small groups of patients. This approach should be reflected in the philosophy and the objectives of the program and the competencies for the total program and those for each course or level of progression.

As a practitioner, the nurse works with other employees of nursing service as well as with representatives of other disciplines. Ideally, the efforts of all these persons are combined and coordinated so that the patient receives comprehensive care. Together, these people constitute the groups that we call the nursing team and the interdisci-

plinary team. For the nurse to function most effectively as a contributing member of these teams, it is advantageous for her to have and to apply knowledge of the group process.

As a student, the nurse should have learning experiences in working with these teams in planning for total patient care. She also has much opportunity to work with her peers in group situations such as post conferences. These experiences could be used in part as a laboratory in which the student can learn about the group process within normal groups. With these experiences as a basis, she can be helped to transfer her knowledge and skill to groups of patients in a normal-to-abnormal sequence as she progresses through the curriculum.

The knowledge and skill requisite to giving nursing care to groups of patients cannot be taught and learned in only one course. Rather, as with many other threads of content, it can be introduced gradually and in a simple form. For example, in the first course in nursing, the student can be guided to look at and study her peer group interactions in such situations as post conference. Concurrently, of course, she would be taught appropriate theory relative to group dynamics. An example of theory might be the functions and roles of group members. As she progresses in the curriculum, the content and learning experiences become more complex and eventually include working with patient groups.

Since one of the major functions of the nurse who works with the mentally ill is to help the patient to engage in relationships that are more satisfactory than those he has had in the past, more emphasis should be placed on the group process in the course or unit in nursing care of the mentally ill. True, an acutely disturbed patient may initially require and receive nursing care on a one-to-one basis, since this may be all the interpersonal contact he can tolerate at the time. However, as he progresses along the continuum toward health, he needs to be assisted to engage in positive interactions with a number of others. As the student of nursing assists him in this task, she assumes the role of the socializing agent. In this role, she relies on her background knowledge of the group process, with which she is already familiar through having used it in normal groups. Now she needs to apply, modify, and enlarge these knowledges and skills in implementing them in the care of the mentally ill. This does not mean to say that this nurse as a beginning first-level practitioner will assume the role of group therapist as this role is generally understood. It does mean, however, that she will help small groups of patients to handle problems of daily living, just as she did with the individual patient. An example of a structured group could be a patient government or discussion group. Another example of a structured group in which this nurse may participate and lead is a remotivation group.

In addition, a student who is being prepared for beginning first-level practice should be given sufficient theory and opportunity for application of this theory, so that she is able to take advantage of unstructured patient situations and help the patients to engage in spontaneous activity and/or discussion groups. Let me emphasize, however, that a beginning first-level practitioner is aware of her limitations in this area as in all others. Furthermore, she seeks supervision in her work with small groups of patients. Depending upon her knowledge and skill, this supervision may be direct or it may be indirect, as in the form of consensual validation of her modified process recordings.

Content concerning the group process is based upon the content from the psychosocial sciences, especially sociology. Broadly speaking, we can draw an analogy: understanding individual behavior and the nurse-patient relationship has its beginnings in content from

psychology; basic content relative to groups is found in the content of sociology. However, only if the nurse faculty are aware of this content will they be able to assist the student in applying and modifying it in the clinical nursing setting. This necessitates optimum or heightened interdepartmental and interfaculty communication.

In summary, the inclusion of content relative to the group process is essential in programs in basic nursing education. Knowledge of both the group process and of individual behavior and abilities gained through application of this knowledge in appropriate clinical experiences will enable the student to render knowledgeable nursing care to patients in a wide variety of situations in her future role of beginning first-level practitioner. This knowledge and skill should also prepare her to function effectively as a contributing member of the nursing team and the inderdisciplinary team.

In planning for including group process content in the curriculum, the same principles of curriculum development are followed as with any other thread of content. The first step is the development of expected competencies, stated in behavioral terms. As the faculty develops these competencies, the inevitable discussion will help to clarify what the faculty sees as the limits of nursing intervention in regard to working with groups for beginning first-level practice in nursing.

If the developed competencies proceed from the simple to the complex, the content that follows will also become progressively more complex. In relation to the group process, the project staff envisions the greatest degree of complexity of content being developed for the course or unit in nursing care of the mentally ill and reinforced in succeeding nursing courses, so that as a beginning first-level practitioner, the graduate will be truly able to render safe, effective nursing care to patients, both as individuals and as groups.

THERAPEUTIC ENVIRONMENT*

Joan E. Walsh

We know that man is in constant interaction with his environment. He influences it and is in turn influenced by it. That is to say, the environment affects both his emotional and his physiological well-being. There are many aspects from which one could look at man's interaction with his environment. It could be viewed from the over-all biophysical standpoint, from the more immediate emotional-social standpoint, including community influences at large on the individual and his family, or from the circumscribed hospital environment when one is ill. For the purposes of this paper, remarks will be confined to the hospital environment.

Inasmuch as the nurse is concerned with all aspects of patient care, she must of necessity be concerned with the effects of the hospital environment on the patient's well-being. In her nursing care plan, she makes provisions for altering or maintaining environmental influences to enhance their therapeutic nature.

In psychiatric nursing, it has long been known that environmental influences on the patient are of paramount importance. In the enumeration of the functions or roles of the psychiatric nurse as she considers the patient's environment, the nurse is often referred to as a sociotherapist. Joyce Samhammer Hays describes the functions of the nurse in this area as creating a familylike environment through accepting, understanding, et cetera; and studying the ward social structure in order to promote healthy association.[1]

The therapeutic environment can be defined from the standpoint of psychiatric nursing as a milieu designed to help patients develop a sense of self-esteem and personal worth, to improve their ability to relate to others, to help them learn to trust others, and to return them to the community better prepared to resume their roles in living and working.[2]

In order to be therapeutic, the patient's environment must be purposeful and planned, taking into consideration physical aspects--i.e., homelike colors, furniture, et cetera, and provision for privacy; personal aspects--i.e., provision for physical needs such as food, cleanliness, rest, safety, et cetera, and acceptance in a friendly, warm atmosphere; and social aspects--i.e., provision for interaction and communication among patients and personnel.

A therapeutic environment meets the basic needs of the individual and provides a testing ground for the patient for new patterns of behavior.[3] It is based on a sound basic understanding of psychodynamics by the staff.

A therapeutic environment respects the individuality of each patient and at the same time provides for participation in democratic group activity. Emphasis is placed on socializing activities, for which the patients are encouraged to take increasing responsibility. Free-flowing communication among patients and staff, among patients, and among staff is essential.

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*Owing to lack of time, this paper was not presented at the workshop.

A true therapeutic environment cannot be achieved unless an atmosphere of acceptance and optimism prevails throughout the unit. Any serious personal or professional conflict between staff members must be recognized and dealt with. The setting of limits is not inconsistent with the concept of the accepting, permissive, democratic atmosphere of the therapeutic environment, but rather is an essential part of it and reflects the realities of living in a democratic society.

The environment can be said to be therapeutic only if the philosophy is consistently implemented over the period of time that the patient is in the hospital. Consequently, it can be seen that the major responsibility for providing a therapeutic environment rests with the nursing personnel, the group of workers who are in the closest continual contact with the patients.

Continual appraisal, evaluation, and modification are mandatory if the therapeutic environment is to be a dynamic living force that helps patients to move in the direction of health.

It is the project staff's contention that this description of a therapeutic environment has implications for nursing care in all situations. Within the project, we are concerned with the education of the technical-level nurse, the beginning first-level practitioner in nursing, including nursing care of the mentally ill. In order to enumerate what the nurse functioning on this level must know, be able to do, and be, the project staff has used the approach of stating terminal expected competencies. When we determined competencies for the technical nursing student, several points that put some limitations on what she can do immediately came to mind:

1. She works as a member of the nursing team.
2. She works under the supervision of a nurse with broad professional preparation.
3. She is aware of her strengths and limitations.
4. She seeks appropriate supervision.
5. She takes directions and follows through on them.

In relation to her consideration of the immediate environment in her nursing care plan for assigned patient(s), she would have the following competencies.

1. She has an awareness and appreciation of the effects of the environment on the patient.
2. She can initiate modifications in the immediate physical environment of assigned patients when needed and when possible.
3. She carries out safety measures as dictated by the patient's needs (both physiological and psychological).
4. She provides a climate of acceptance in a friendly, warm atmosphere.

Following are examples of terminal expected competencies related to the student's responsibilities toward the over-all ward environment.

1. She identifies disruptive and therapeutic factors in the ward environment.
2. She is aware of the influence of the personnel on the ward environment.
3. She contributes to the establishment and maintenance of a therapeutic ward environment.

It is obvious, then, that in basic educational programs for the technical-level nurse, the therapeutic environment is a thread of content that should be woven into the entire nursing curriculum. As with other threads of content, content and learning experiences

related to the therapeutic environment should be planned and introduced at the beginning of the curriculum. The content should proceed from the simple to the complex and should be based on concepts and content that the student has learned in the behavioral sciences. Learning experiences and evaluation methods are suggested by the expected competencies.

Some of the topics for consideration under content could be, for example: the organization and formal structure of the hospital, including communication routes; the informal social structure, including bids for authority and status, cliques, and rituals; the philosophy of institutional care; and staff attitudes and expectations. These topics should be considered from the standpoint of both general and mental hospitals.

The beginning first-level practitioner in nursing care of the mentally ill is not prepared to work in a therapeutic community. The therapeutic community is a highly specialized form of therapeutic environment and is a prescribed treatment modality. This is not to say that the technical-level nurse should not know what a therapeutic community is or have knowledge of the underlying philosophy of this concept of treatment. If, as a graduate, she is employed in a setting that utilizes the therapeutic community as a form of treatment, she will require supervision and additional preparation.

References

1. Joyce Samhammer Hays. "The Psychiatric Nurse as a Sociotherapist." Amer. J. Nurs. 62:64-67, June 1962.
2. Dorothy Mereness and Louis J. Karnosh. Essentials of Psychiatric Nursing. St. Louis, C. V. Mosby, 1966, pp. 55-56.
3. Martha M. Brown and Grace R. Fowler. Psychodynamic Nursing--A Biosocial Orientation. New York, Saunders, 1961, pp. 282-290.

THE TREND TOWARD COMMUNITY MENTAL HEALTH CENTERS

Wallace Mandell

The community-based approach to mental illness and health attracted national attention as a result of the findings of the Joint Commission on Mental Illness and Health, which was established by Congress under the Mental Health Study Act of 1955. After five years of careful study of the nation's problems of mental illness, the commission recommended that no more large mental hospitals be constructed and that a flexible array of services be provided for the mentally ill in settings that disrupt as little as possible the patient's social relations in his community. The core of the plan is to move the care and treatment of the mentally ill back into the community to avoid disruption of normal patterns of living and the estrangement often accompanying distant and prolonged hospitalization. The concept is that hospitalization may produce an iatrogenic disease. The goal is to make the full range of help that the community has to offer readily available to the person in trouble, to increase the likelihood that troubles can be spotted and help provided early when it can do the most good, and to strengthen the resources of the community for the prevention of mental disorder.

The model community mental health center, as envisioned in 1966, cannot be looked to for a unique or final solution to mental health problems. Various patterns must be tried, plans must be revised in the light of evaluated experience, and fossilization must be rigidly avoided. Currently, plans for the first comprehensive centers are being drawn under the present federal legislation. Even so, other bold approaches to the fostering of human effectiveness are being promulgated under education and economic opportunity programs. There will be need to think together in terms of the relationship between mental health, education, and economic opportunity programs.

The comprehensive mental health center represents a fundamental shift in strategy. Historically, the preferred treatment programs have removed the mentally ill person from society, putting him out of sight and mind until he is restored to normal functioning. Heretofore, the community relegated its responsibility for the mental patient to the distant mental hospital. In the new way, the community accepts the responsibility of coming to the aid of the troubled citizen. The person remains in his community, often not leaving home. He remains close to family, friends, and professional help. The center's program of prevention, protection, and early intervention would involve it in many aspects of community life and institutions not normally considered mental health agencies, such as schools, churches, welfare agencies, the police and the courts, and industrial and community councils. Mental disorder is not the private misery of an individual. It often grows out of, and usually contributes to, the breakdown of normal sources of social support and understanding, especially the family. It is not just the individual who has faltered. The social system in which he is embedded--family, school or job, reli-

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gious affiliation, friendship--has failed to sustain him as an effective participant. From this view of mental disorder as rooted in the social system, the objective of the mental health center's staff should be to help the various parts of the social system to function in ways that develop and sustain the effectiveness of individuals. It should help these systems to regroup their forces to support the person who becomes troubled. The therapeutic concept involves regrouping of social forces.

Mental health personnel should not be misled by particular names or particular agency job descriptions. The task is more than helping individuals drawn from a catchment area. The community mental health center's task goes far beyond giving or selling professional services to troubled people on an individual basis.

The comprehensive center concept was developed for a model community small enough for face-to-face contact between leadership and citizens. It is difficult to visualize in detail how such comprehensive mental health centers will function in a large urban setting. On any given day 66,000 citizens of New York City are inpatients occupying psychiatric beds. Another 121,000 individuals are outpatients in over 160 clinics. Already, 1 out of every 50 adults in the city has experienced a hospital stay for a psychiatric disturbance. Consider the range of the agencies and the pressure to deal with the economics of this problem. There is, therefore, pressure to produce mass service organizations. On the other hand, we believe that effective treatment must be individualized, be dependent on an individual diagnosis that leads to a specific plan of treatment for the individual. Categories of society cannot be treated by psychotherapy. In order to bridge the two problems, services will be regionalized within the city. The present concern is, How many regions within the city or within the state should exist? The disagreements are as to whether the unit of population served should be 50,000, 100,000,or 200,000, considering travel patterns and the economic organization of the region. The principle most used is that the complete range of services required for the psychologically disordered individual ought to be "within reasonable travelling distance" or, in New York City, "within walking distance" of the individual's home.

The range of services that will be included, though probably not under one roof, are as follows: (1) inpatient care for persons who need intensive care or treatment around the clock; (2) outpatient care for adults, children, and family; (3) partial hospitalization, day care, and treatment for patients able to return home evenings and weekends; (4) night care for patients able to work but needing limited support or lacking suitable home arrangements; (5) emergency care on a 24-hour basis; (6) consultation to and education for community agencies and professional personnel who deal with psychologically disordered individuals. In addition to these six essential services, other services that will make for an optimal community mental health program are being considered. These are: (1) diagnostic and rehabilitative services, including social and vocational rehabilitation; (2) precare and aftercare, including screening prior to hospital admission; (3) home visiting and halfway houses after hospitalization; (4) training for all types of mental health personnel; (5) research and evaluation in each of the community mental health centers.

It is not necessary to think of the center as being physically located under one roof. The administration must be under one organization with shared personnel. Even now personnel are rotated in segmented agencies to lay the foundation for new staff attitudes in order to break down attitudes of those who have been completely trained and who have always worked in state hospitals.

Which agencies will carry on what mental health functions does not seem too important. Rather, the important principle is that the complete array of services be carried

on in each community. Which agency carries out a specific function is the result of historical precedent. Professional careers will be made, people will become famous, and people will be forgotten in the battle over which agency captures what part of the funds for carrying out a particular service. I do not believe that this is of interest to you as educators, and I personally add my warning, don't get involved. The important thing is that personnel be trained to carry out mental health functions.

Individual therapeutic intervention has been the focus of teaching in psychiatry, psychiatric nursing, and nursing in general. Crucial as therapeutic intervention is and will continue to be, a greater emphasis will be placed on attempts to limit psychological disability, which may be the concomitant of psychological disorder. Even where psychological disorder cannot be cured, methods are at hand for effectively limiting the associated disability. It is a common experience among all the professions in the various health fields that individuals with similar psychological symptomatology may be functioning at varying levels of effectiveness. There is a growing consensus that hospitalization is as much a function of inadequate or socially unacceptable performance of the various roles an individual must occupy in his life as it is of the specific character of his psychological symptomatology. It is a common observation that there are people in the community who are more unusual in certain aspects of their personal living than patients in mental hospitals. It might be helpful to explore in greater depth the reasons for hospitalization or referral for psychiatric care.

The following discussion is an attempt to offer a theory, or a set of concepts, useful in conceptualizing the reasons people come to psychiatric services, and to give examples of the types of mental health services that can be provided for limiting disability. The highest demand is for mental health services dealing with individuals so psychologically disabled that they must be withdrawn from the community at large because they pose a danger to the community or to themselves.

Another group for whom mental health services are demanded are individuals who are psychologically disabled to the extent that they cannot conform to standards of major institutions that are legally charged with carrying out public functions. Schools are legally charged with producing a certain level of achievement and with the general care of the students; the Armed Forces are legally charged with the general care of their personnel; the police maintain public order; and law enforcement agencies such as the courts and the various arms of the court are legally charged with carrying out public functions.

Another group that asks for mental health services is composed of individuals who are psychologically disabled in performing effectively at work, in the family, in love relationships, in maintaining satisfying friendships, and in community interaction. These individuals come voluntarily for services. This demand for mental health services can be understood as arising from the psychological inability to function effectively in at least one of four areas, i.e., work, family, friendship, or community. The urgency of the demand is in part related to the danger to the community of the failure in performance. Thus, there is both a source of the demand and an urgency.

The channel of request for the mental health service is related to the area of performance and the institutions charged with public responsibility in that area. For instance, the major source of referral for hospitalization is the police. As many as 80 percent of the requests for institutionalization in a state mental hospital may come through the police. The police are not the cause of the disturbance, but the disturbed individual falls into their domain of public charge and responsibility.

The inability to perform effectively may have a number of sources--for example, lack of ability or lack of education and training. Lack of access to roles is also important, since individuals with appropriate ability or education and training may not have opportunities to step into roles where they can utilize their ability and training. Another source of ineffective performance is the individual's social interaction style; that is to say, an individual's pattern of interacting with other people may be such that they refuse to offer him opportunities to perform effectively. There is also psychological disorder as a basis for inadequate performance. Generally, the bases of psychological disorder are: (1) psychic conflict; (2) affective disorders, including anxiety states; (3) cognitive disorders; and (4) behavior symptoms. Within our culture, communities and subcommunities have various standards of performance for each of the areas of performance discussed previously (work, community, friendship, and family). Within any given community, mental health services may or may not be available. Where they are lacking, pressures develop for services.

A general theory our group has formulated and found useful in developing such services is our "social credit" theory. Its basic concepts stem from the fact that every individual has needs. He wants goods, services, and psychological comforts from others. These goods, services, and psychological comforts, called "valueds," are obtainable through interaction with other individuals in the community. The kind of interaction that will obtain valueds for an individual is exchange. The individual wants goods, services, and psychological comforts from other individuals, and he obtains these by exchanging with other individuals the valueds--the goods, services, and psychological comforts--that he possesses. At any particular time, therefore, the individual has at his disposal resources that he can exchange with other individuals for the things that he wants. He can accumulate obligations on the part of other individuals. The exchange doesn't have to be a contemporaneous transaction. Valueds can be exchanged for promises, to be repaid later. This exchange is a normal process that facilitates family relationships, clan relationships, and community relationships. This process also occurs in work, because no one individual can produce everything he needs. In society, with its division of labor, people specialize and are able to produce health services, for example, in return for bread, a place to live, affection, and psychological comforts. These transactions are facilitated by the translating of services into dollars.

There are many things that cannot be translated into dollars but are done on the basis of credit. Individuals who are unable to perform effectively in the community are unable to develop social credit. They are unable to develop obligations on the part of other people to provide them with support. Actually, the point at which the individual withdraws from the community is when his social credit runs out. Simultaneously, the people in the community are no longer willing to provide the individual with the goods, services, and psychological comforts he needs, because he is not returning to them enough for what he is asking. Some people are very demanding, but everybody is quite willing to fulfill their demands because they in turn are very giving. Some people are very demanding and are not very giving, and interaction with them is avoided. In fact, they may get to be such a burden that family and friends ask that they be withdrawn from the social system. As supervisors know, there comes a time when a person who is working under them occupies more time and demands more than that person returns to the service. At this point the individual is removed from the system. There are various channels through which individuals are withdrawn, but there are always channels available within the community. One of the intermediate steps is to ask that something be done so that the individual

will increase his output, thus making us willing to give him more services and more support.

In an analysis of 50 suicide cases, it became clear that the family and intimates of the suicide finally said to him, "We have had it with you. We are not going to give you any more of that which you demand from us." Whether spoken or not, somehow the message finally gets through to the suicide, and he is baffled. How can he get what he wants? The only tool he has left is to say, "I can make you feel guilty. If I can't give you anything that will make you do what I want, I can threaten you by making you feel guilty." The suicide fantasy that accompanies this situation is, "I will attend my own funeral, and you will be very unhappy, and then you will be sorry you didn't do what I wanted."

The pressure for mental health services for any individual is related to the resources of the individual at any particular time in terms of his social credit and to the demands he is making on the community. The goal of the mental health service agency is to prevent disability, to limit withdrawal, and ultimately to improve the satisfaction of individuals by helping them perform at a level that will enable them to exchange their services for the goods and services they desire. Perhaps in an ultimately good society individuals would get what they need simply because they exist, but within our culture an individual must also produce and give in order to get what he needs. It then becomes a very important task of the mental health agency to help the individual to be productive and effective. The agency must evaluate the individual's demands, his resources for performing at a level to meet his demands, and the sources of the discrepancy. He may be making inappropriate demands: his goals may be so high that no one in his community could meet his demands. He may not have the ability to perform. He may not have the necessary education and training. He may not have access to the roles that could satisfy his demands, or he may not have the necessary social interaction style, which is skill at trading what one has for what one wants. Finally, he may have a psychological disorder that incapacitates him in any one of these areas. The agency can help the individual to set more realistic goals, it can refer the individual to agencies that can improve his performance, or it can control or remove the psychological disorder. Current psychological therapies are probably effective for only about 25 percent of the various psychological disorders. It is the wise agency that uses its psychological skills and therapeutic energy in those cases that are likely to benefit from the treatment.

Using this schema of analysis, what are the various kinds of mental health agencies in the community and what do they do? Some confusion is caused by the fact that three or four functions may be performed by one agency in a community. These functions may be rearranged in another agency in another community. The community mental health question is whether the community has an array of all the services needed.

A primary function of mental health agencies is diagnosis. Diagnostic services are based on interview, psychological testing, and observation. Some agencies have facilities for observation. An instance is a hospital in which there are trained observers, such as nurses, aides, and doctors. Since observation becomes administratively easier in a hospital setting, individuals are frequently placed there for that purpose. However, the hospital setting may not be therapeutic. It may even cause a disease or distress. On the other hand, psychiatric interviewing and psychological testing can be carried on in any facility, whether it be a hospital, an outpatient psychiatric clinic, or even a general health clinic. It doesn't make very much difference where the interview or psychological testing goes on. As a result, you will find the diagnostic services of mental health pro-

grams in a wide array of community agencies, and these are generally organized according to the populations they serve. For instance, the schools have testing programs, the general health clinics do interviewing, and public health nurses and physicians do interviewing at home. Hospital emergency rooms are utilized, though poorly. Court and police facilities are places where diagnosis goes on. Finally, there are the outpatient psychiatric clinics.

A psychological disability seen at these facilities may be the result of a temporary loss of usual support. It may be the result of a long-term failure in functioning. It may be the result of a physical trauma, which is physiologically based, such as disease, pregnancy, toxicity, or an accident. It may be the result of social trauma, such as death, unemployment, or divorce. It may be the result of a neurologic inadequacy, or it may be the result of an unusual situation of living. These categories are important in a diagnostic facility because it is on this basis that referrals should be made.

Once a decision has been made in the diagnostic process as to which of the factors above are involved, consideration is given to the kind of intervention that is most likely to be effective. Examples of potentially effective intervention are: temporary support for a temporary loss, such as homemaker services, catharsis, a vacation; reeducation in social functioning, school, vocational rehabilitation, membership in certain kinds of clubs and settlements; physiologic intervention for those people who have physiologic trauma; or, finally, removal from an inappropriate environment that gives the individual poor training or continually traumatizes him. For a psychological disorder, psychologic psychiatric intervention is required.

Once the individual has passed through the diagnostic service, no matter where it is located, there is a referral service. In state hospitals and in psychiatric outpatient clinics, referral is internal, and so the process is hidden. For instance, in a child guidance clinic, after the diagnostic study, a decision is made as to the recommendation for treatment. The individual is then referred for service, but because the service is most likely to be provided within the institution, the referral usually takes the form of an interdepartmental referral, which is always accepted. In a large hospital, the referral may not be accepted, since the therapy waiting list may be crowded. When the referral is outside the agency doing the diagnosis, it has less chance of being accepted. For instance, an outpatient clinic may diagnose an individual as needing inpatient care and refer him to the state hospital. The state hospital may resist such referrals on a policy basis. The referral ordinarily goes to one of a group of agencies, which are those designed to help the individual to improve his performance. They can provide information, education, and training or they can provide access to new social roles. An example of agencies that provide information might be a vocational counseling service or the state employment service.

A second group of agencies to which the referral may go are agencies that can help the individual to set appropriate goals. When individuals have been setting inappropriate goals because of their values, they can be referred to religious leaders of their own persuasion for help in thinking through, on the basis of religious counseling, the appropriateness of the goals and standards that they have set. Another area in which the individual may need to set appropriate goals is the area of work, where vocational guidance services could be utilized. There are an increasing number of agencies that can provide vocational guidance for the individual. For example, an individual who really should not be trying to be an engineer, because of his level of ability and talent, might very well try to be a draftsman and thereby reduce some of the strain he experiences.

Referral may be to agencies that can help to limit or cure the psychological disorder directly. These are the clinics, the inpatient units in general hospitals, the long-term hospitals--usually state hospitals, and the transitional and halfway agencies.

Referral may be to outpatient treatment. The attempt here is to directly limit or control the psychological disorder. One of the techniques available is medication in one of two broad classes: the individual is either slowed down or speeded up; both classes of medication may also limit the experience of anxiety. They do not cure, they help set limits to the patient's extreme responses. Individual psychotherapy, geared primarily to the more intelligent of the population, provides highly individualized interpersonal interaction appropriate to exploring and reducing psychic conflict. Group psychotherapy is similar in aim but has greater focus on interindividual conflict. Finally, there is psychoanalysis, which is an intensive interpersonal interaction providing the individual with information about his longstanding characteristic patterns of reaction to individuals and events in the world. Psychoanalysis focuses on an exploration of the sources of these patterns of response and thus opens up opportunities to change them. Psychotherapies cannot change all longstanding patterns of interaction. One of the outcomes of therapy may be to help the individual learn that there are certain kinds of situations that he ought to avoid because he cannot handle them. An outpatient clinic may also provide temporary emotional support, a wise, friendly person who will listen to the individual's troubles. This service is frequently confused with psychotherapy, but it may be provided by many individuals who are not highly trained psychotherapists.

Inpatient treatment effects removal from inappropriate environments. This removal can be for a very short time, as in the psychiatric unit in a general hospital. Such removal allows for the control of psychological disorder through medication, particularly where observation and regulation of dosage is necessary; for the provision of electroconvulsive therapy; or for the use of milieu therapy in a controlled social environment. Inpatient treatment also has the advantage of allowing for reeducation in multiple areas of functioning, since the individual is under control for the entire day.

Finally, there are transitional services in which an attempt is made to retrain the individual under conditions more usual and more like the everyday conditions under which people live in the community. These services can provide temporary support, such as catharsis, job placement, and recreation. In addition, long-term support, such as economic support or supervised recreation and friendship activities, can be provided for individuals who need more supervision than they would otherwise be able to obtain by themselves. That is to say, a certain portion of our population will never be able to fully control and regulate their lives, and it is currently believed that it is a mistake to insist that these individuals be placed in long-term hospitals. These individuals can live in what are called transitional communities or transitional agencies where they can work part of the day or do many of the things that other people do in the community at large, and they come back only at night or on the weekends or for supervision. These transitional services are generally called halfway houses.

It is obvious that a large proportion of the facilities and programs needed for improving individuals' performance and social credit is in the hands of agencies and institutions other than the mental health agency. The task of the mental health agency is to make these other agencies more amenable to providing their services to psychologically disabled individuals and to improving their services so as to increase the likelihood that the psychologically disabled will achieve some performance ability. Mental health agencies can help these other agencies by helping them to devise appropriate techniques for

working with the disabled. Mental health personnel can help the staffs to tolerate the tension that results from working with the psychologically disabled. These agencies, by strengthening their abilities to deal with psychological stress, can improve their services so that they do not provoke psychological disorders. This is done through improving the human relations component of agency management, so that agency staff will improve their skills in working with the psychological component of services to all clients.

Many of the functions described, including diagnosis, referral, and the various kinds of treatment, can be carried out by nurses or nursing staff if training is provided to the level of mastering each particular technique. It is certainly important that nurses be given the amount of preparation necessary for preparing a patient for electroconvulsive therapy and then observing the patient to make certain that nothing goes wrong. The amount of preparation involved in becoming a good listener, in providing catharsis and support, is at quite another level. Finally, nurses must be knowledgeable about which of the agencies in the community carries out each mental health function. This has to be learned for each individual community, because the same function may be carried out by different agencies in different communities. The problem for nursing educators becomes one of deciding how much of an investment in training they wish to make in educating a nurse for carrying out a particular skill. The difficulty has been that there is great demand for these various functions and a concomitant shortage of personnel. Being human, nurses are pressured to attempt to undertake some of these functions even though not prepared to do so. One of the reasons for this is that there is a sharp increase in the rewards, in terms of prestige, status, and finances, available to the person who carries the label of mental health worker.

Nurses already participate in the functions of screening and diagnosis. All nurses in clinical settings are in situations wherein their alertness is decisive. They all must, therefore, have some preparation in the recognition of signs of psychological disorder and disability. In the area of therapeutic intervention, all nurses need preparation in listening techniques. Beyond this, it depends on the nursing profession to determine the level of responsibility nurses can assume within the context of nursing care.

SUMMARY OF PARTICIPANTS' REPORTS

Following is a topical compilation and summary of the responses of the workshop participants regarding (1) plans for the incorporation in their curriculums of expected competencies and for the organization of content developed by them at the workshop and (2) anticipated problems in carrying out their plans.

The number of plans and problems expressed by each faculty group varied widely. Therefore, while the following summary will give the reader some indication of the types of plans and anticipated problems expressed by the workshop participants in general, it will not be indicative of the number of plans and problems expressed by the representatives of each individual school or program.

The headings under which the items are listed were not suggested to the participants, but rather are a result of an analysis by the project staff of the plans and anticipated problems stated by the workshop participants. Furthermore, the order in which the items are listed is a result of this categorization and is not indicative of the order of the participants' responses.

The categories that emerge from the participants' statements of plans were over-all faculty orientation, planning for integration of psychiatric-mental health nursing content throughout the curriculum, and planning for the course or unit in nursing care of the mentally ill. The diploma schools had the additional category of planning for evaluation.

ASSOCIATE DEGREE PROGRAMS

Plans

A. Over-all Faculty Orientation.

1. Involve the total faculty in implementation.
2. Identify the conceptual framework to be used as the basis for integrating mental health content throughout the curriculum.
3. Define the educational and the psychiatric terminology to be used.

B. Planning for Integration of Psychiatric-Mental Health Nursing Content Throughout the Curriculum.

1. Revise, redefine, and spell out expected competencies in behavioral terms.
2. Develop expected competencies, and identify nursing content relative to mental health for each clinical course.
3. Have the nursing faculty acquaint themselves with the content taught in related psychosocial science courses and work with faculty in this department toward including essential foundational content for nursing.
4. Select one area of psychiatric-mental health nursing content, and follow it through the entire curriculum.

5. Separate mental health content from the psychiatric nursing course, and integrate mental health content in other appropriate areas.
6. On the basis of the expected competencies related to the nurse-patient relationship, process recording, and the group process, reorganize content in the nursing courses.
7. Initiate the nurse-patient relationship, process recording, and the group process in the nursing courses prior to the psychiatric nursing course.
8. Add learning experiences in working with groups of patients and staff throughout the total curriculum.
9. Involve the psychiatric nursing instructor as a resource person in other clinical areas.

C. Planning for the Course or Unit in Nursing Care of the Mentally Ill.

1. Revise the content and the planned learning experiences in the course in psychiatric nursing.
2. In the course in psychiatric nursing, build on what has been taught previously in nursing courses and courses in the psychosocial sciences (e.g., the nurse-patient relationship, process recording, and the group process).

Problems

1. Having the nursing faculty realize that the material presently included in the unit in psychiatric nursing has applicability in other nursing courses.
2. Moving to the first year selected content currently being taught in the second year.
3. Terminology.
4. Having clinical facilities which provide opportunities for students to practice what they have learned regarding the psychosocial aspects of patient care.
5. Free time for faculty to work on curriculum revision.
6. Turnover in faculty.
7. Faculty resistance.

DIPLOMA SCHOOLS

Plans

A. Over-all Faculty Orientation.

1. Review and discuss all materials from the workshop at curriculum meetings.
2. Define terms to be used.
3. Provide inservice education for faculty (e.g., use of process recordings and small group conferences).

B. Planning for Integration of Psychiatric-Mental Health Nursing Content Throughout the Curriculum.

1. Hold total faculty discussions of expected competencies in general nursing and their progression throughout the curriculum.
2. Include instructors in the psychosocial sciences in discussions of competencies.
3. Establish level competencies.
4. Identify additional competencies in the psychiatric-mental health area, and plan for resulting content and learning experiences.
5. Identify the specified content and learning experiences that are already being taught,and make additions as needed.
6. Integrate psychiatric-mental health content (e.g., the nurse-patient relationship, the group process) from level one throughout the curriculum, moving from simple to complex, from obvious to abstract.
7. Work more closely with affiliating agency in integration of psychiatric-mental health concepts.
8. Emphasize need for more specific identification of mental health concepts in course outlines and nursing care plans, thereby involving both faculty and students.
9. Focus more on student self-awareness.

C. Planning for the Course or Unit in Nursing Care of the Mentally Ill.

1. Have an orientation for students with a faculty member of the affiliating agency prior to the psychiatric nursing experience.
2. On the basis of the previously integrated psychiatric-mental health nursing content, shorten the course in psychiatric nursing and offer it in the senior year.
3. In the course in psychiatric nursing, build on students' previous knowledges and skills in relation to mental health content (i.e., the nurse-patient relationship, the group process, et cetera).
4. Define more clearly and organize the group process content in the psychiatric nursing course outline.
5. Continue to promote discussions with small groups of patients led by students in the course in psychiatric nursing.
6. Place more emphasis on content directly related to nursing care of mentally ill patients in the course in psychiatric nursing.
7. Modify the competencies for psychiatric nursing so that they give directions for evaluation.

D. Planning for Evaluation.

1. Reevaluate the learning experiences.
2. Make use of the critical incident technique in performance evaluations.

Problems

1. Fogginess about what psychiatric-mental health content should be included in areas other than psychiatric nursing.
2. Having instructors in other areas be aware of their responsibility for recognizing the mental health aspects of all clinical situations.

3. Orienting faculty to the need for integration of psychiatric-mental health nursing content throughout the curriculum.
4. Assisting faculty to gain increased knowledge and skill in the use of process recordings and in group process.
5. Changing attitudes and clearing up confusion over the role of the nurse in the group process.
6. Recognition of the importance of process recordings and group dynamics.
7. Faculty resistance.
8. Insufficient time in nursing courses to teach psychiatric-mental health nursing content.
9. Free time for faculty to work on curriculum revision.
10. Making additions to and changes in courses already planned for the next year.
11. Placement of the psychiatric nursing course in the curriculum.
12. Students coming to courses with different backgrounds, due to the necessity of rotating them through their courses and clinical experiences.
13. Including sociology and psychology early enough in the curriculum to be used as a foundation for content in interpersonal relationships and the group process.
14. Shortage of qualified faculty members.
15. Devising evaluation methods to assure that competencies are being met.

APPENDIX A. SELECTED OPERATIONAL DEFINITIONS

The definitions given below are an attempt to bring together in one place the precise meanings of the technical terms as used in this project. The definitions are derived from recognized authorities in education and nursing. Where these are quoted verbatim, references are cited in the usual way. In other cases, we have freely paraphrased the words of several authorities but are still able to cite chapter and page of particular works. Frequently, however, a definition combines elements from a number of different sources, elements so interwoven that definite attribution can no longer be made. In such cases, our references become bibliographic lists rather than citations.

Knowledge: An idea or a phenomenon to which a student has been exposed and which she can remember either by recall or recognition.[1] Frequently manifested by the student's capacity to name, describe, list, state, explain, et cetera.[2]

Skill: A mode of operation and generalized technique for dealing with a problem. Little or no specialized and technical information is required. Although a skill can be learned, its mastery is more dependent upon natural endowment and experience than on formal education. A skill may also be referred to as an art.[3]

Ability: The student's concurrent utilization of knowledge and skill in a situation different from the one in which learning took place.[4] Frequently manifested by the student's capacity to solve, interpret, apply, work, do, et cetera.[5]

Attitude: A persistent disposition primarily grounded in emotion and expressive of opinions rather than beliefs. Implies action that is either positive or negative, that varies in intensity, and is directed toward a person, a group, an object, a situation, or a value system.[6] Frequently manifested by what the student enjoys or does not enjoy, chooses to do or not to do, et cetera.[7]

Appreciation: The full awareness, recognition, and just estimation of a thing's worth and scope.

Philosophy: The beliefs through which man tries to understand himself and the world in which he lives. In relation to education, these beliefs underlie and provide the rationale for the goals of the educational process and the methods used in the attainment of these goals.[8] For the purposes of this study, the word "beliefs" shall be used interchangeably with the word "philosophy."

Level of Achievement: A position or rank in a progression of steps derived from the objectives of the learning experience and resulting in terminal behavior. A student's level of achievement is manifested in her behavior.

Terminal Behavior:[9] The performance of the student that has been established as the minimal acceptable level of achievement at the end of a planned unit of instruction, and that indicates that the learner has achieved the objective(s); i.e., there has been a behavioral change in the student. For the purposes of this study, the term "expected competencies" shall be used interchangeably with the phrase "terminal behaviors."

Expected Competencies:[10] A description of the desired outcome(s) of a program of studies, a course, or any given learning experience. Stated in behavioral terms, which describe what the learner is to be like as a result of the learning experience. Indicate the minimal acceptable level of achievement. Derived from and consistent with the philosophy of the program.

Evaluation: A process for determining to what extent the learning experiences as developed and organized are actually producing the desired results. Implied in the term are (1) an appraisal of the entering behavior of students, since it is change in these behaviors that is sought in education, and (2) more than a single appraisal at any one time, since in order to see whether change has taken place, it is necessary to make an appraisal at an early point and other appraisals at later points to identify changes that may be occurring.[11]

Learning: The acquisition of knowledges, skills, and abilities that result in a change in behavior in the learner. Has the characteristics of being unitary, individual and social in context, self-active, purposive, creative, and transferable.[12]

Learning Experience: The interaction between the learner and the external conditions in the environment to which he can react. These conditions are purposefully planned so as to stimulate the desired type of reaction in the learner.[13]

Integration: "The process of forming new, larger, and more comprehensive whole responses by which differentiated objects and activities are apprehended. It is the combining of details which emerge from large wholes and ultimately acquire such a degree of individuality and specificity that they are united with other particulars and are reorganized into a coherent pattern."[14] For the purposes of this study, the learning experiences provided by the instructor will be such that concepts, principles, and theories from psychology and sociology as well as mental health concepts, principles, and theories relevant to nursing will be interwoven throughout the clinical courses in the nursing curriculum. While learning experiences that facilitate integration of content are provided by the instructor, the process of integration takes place within the student.

Concept: A class of a number of objectives, events, things, and behaviors that differ in appearance. A mental image of a thing formed by generalization from particulars. E.g.: chair, house, round, tall. Concept achievement is observed when the student becomes capable of responding to different objects (events and behaviors) as if he were placing them in one or more classes (classifying them into one or more categories).[15]

Content: Matter that is dealt with by, or presented in, a field of study. This matter is specifically stated and is derived from the objectives of the learning experience.

Psychiatric-Mental Health Nursing Content: For the purposes of this project, psychiatric-mental health nursing content is considered to be the knowledges that are related to the understanding of individual and group behavior. These knowledges are based on the psychosocial sciences, the biophysical sciences, and psychiatry. When applied in the practice of nursing, these knowledges are manifested in abilities such as nursing interaction, nursing intervention, and the nurse-patient relationship, on both an individual and a small-group basis. Inextricably involved in all these abilities are communication and/or interviewing skills, skills in environmental manipulation, and appropriate attitudes in giving nursing care to all patients, i.e., both the physically and the mentally ill. Therefore, psychiatric-mental health nursing content is part of all nursing content.

Nursing: One of the health occupations, which provides service to the individual, the family, and the community in health and in illness. The occupation of nursing includes several levels of practitioners: professional, technical, and vocational.[16] In addition, there is a group of semiskilled workers who assist the nurse in her practice.

Nursing as an occupation is an art and a science that requires the application of knowledge and the principles of biological, physical, and social sciences in the prevention of illness and the treatment and rehabilitation of individuals in need of health services.[17]

The distinctive feature of nursing practice is the responsibility for doing for (or along with) a person, in whole or in part, that which he and/or his family ordinarily would do but are unable to do for a time or at all times.[18] This practice is directed toward identifying and meeting in varying degrees the physical, social, emotional, and spiritual needs of the individual, to the end that he is enabled to achieve or resume his position in society, function within the limitations imposed by his illness, or conclude his lifespan as comfortably as possible.

There are seven areas of nursing function, the first six of which are independent:[19]

1. The supervision of a patient involving the whole management of /nursing/ care, requiring the application of principles based upon the biologic, the physical and the social sciences.
2. The observation of symptoms and reactions, including symptomatology of physical and mental conditions and needs, requiring evaluation or appli-

cation of principles based upon the biologic, the physical and the social sciences.
3. The accurate recording and reporting of facts, including evaluation of the whole care of the patient.
4. The supervision of /nursing personnel and the coordination of/ others, except physicians, contributing to the care of the patient.
5. The application and execution of nursing procedures and techniques.
6. The direction and the education to secure physical and mental care.

The one dependent area of nursing function is:[20]

7. The application and the execution of legal orders of physicians concerning the treatments and medications, with an understanding of cause and effect thereof.

In addition to the broad legal nursing functions outlined above, nursing also includes the following more specific functions:[21]

1. Ministering to the basic human needs.
2. Teaching self-care, or counseling on health.
3. /Participating in/ the patient's /restorative/ activities in modifications of daily living.
4. Planning with the patient for self-care, which is an outgrowth of managing the care for him--determining and timing the course of action and controlling the manner of its performance.
5. Communicating /and interacting/ with the patient throughout all /nursing functions/--/to give the patient opportunities/ to develop a sense of trust, a feeling of significance and ultimately of self-realization.

Psychiatric Nursing: The field of nursing in which the major therapeutic goal of nursing care provided to patients is the promotion of mental health, the prevention and the detection of mental illness, and the treatment and the rehabilitation of patients with psychiatric disorders. In providing such care, the function of the nurse is not different in nature from nursing in other clinical fields, but does differ in its primary focus on interpersonal one-to-one and group relationships.[22]

More specific functions of the nurse include:[23]

1. Creating a therapeutic environment--acceptance, understanding, and provision of opportunities for the patient's emotional growth.
2. Studying the ward social structure in order to promote healthy socialization.
3. Establishing relationships with individual patients.
4. Establishing relationships with groups of patients.
   a. Structured or formal groups (patient government meetings, remotivation, activity groups, et cetera).
   b. Unstructured or informal groups (spontaneous discussions, et cetera).
5. Intervening in crisis situations.

The general goal of psychiatric nursing is to help patients to accept themselves and improve their relationships with other people.[24]

The field of psychiatric nursing includes several levels of practitioners--the professional psychiatric nurse (clinical specialist), the professional nurse, the technical nurse, and the vocational nurse--all of whom work with patients who are mentally ill. In addition, there is a group of semiskilled workers who assist the nurse in her practice.[25] For the purposes of this study, beginning first-level practice in psychiatric nursing shall be referred to as "nursing care of the mentally ill."

Technical Occupation: A vocation requiring skillful application of a high degree of specialized knowledge together with a broad understanding of operational procedures; involving the frequent application of personal judgment; usually dealing with a variety of situations; and often requiring the supervision of others. It offers the opportunity for the worker to develop an ever increasing personal control over the application of his knowledge to his work and usually requires fewer motor skills than a trade or a skilled occupation and less generalized knowledge than a profession.[26]

Beginning First-Level Practitioner: For the purposes of this study, a beginning practitioner is a technical nurse who has graduated from a state-approved diploma school or associate degree program in nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience in nursing after graduation.

A first-level practitioner administers direct nursing care, i.e., she performs intermediate nursing functions requiring skill and some judgment in the presence or at the bedside of the patient.[27] She is a contributing member of the nursing team and works under the supervision of a nurse with broad professional preparation or the physician.[28] She assumes some responsibility for the direction and supervision of those ancillary personnel who are members of the same team.

Beginning First-Level Practitioner in Nursing Care of the Mentally Ill: For the purposes of this study, a beginning practitioner in nursing care of the mentally ill is a technical nurse who has graduated from a state-approved diploma school or associate degree program in nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience in nursing care of the mentally ill after graduation.

A first-level practitioner administers direct supportive nursing care to the mentally ill patient on a one-to-one or a small-group basis. This nursing care is rendered in the daily living situation in which the nurse and patient find themselves and is consistent with the over-all treatment goal determined with and for the patient by the interdisciplinary team. The nurse focuses on strengthening the patient's areas of health and deals only with those thoughts and feelings that the patient brings up and with his behavior. Her nursing care is purposeful and planned, and although it may take many forms, it is based on her knowledges, skills, abilities, attitudes, and appreciations about the behavioral manifestations of the major forms of mental illness. Her primary therapeutic tool in her interactions with patients is "use of self."

In all her activities, the beginning first-level practitioner in nursing care

of the mentally ill functions under the supervision of a nurse with broad professional preparation in nursing or psychiatric nursing. She is a contributing member of the nursing team and as such functions as a member of the interdisciplinary team as they establish and implement total treatment plans for the patient.

Relationship: The state of being mutually or reciprocally interested or influential, thereby being connected.

Interaction: Mutual or reciprocal action or influence which produces an effect, especially a change in the condition of something.

Interpersonal Relationship:[29] An interaction between the individual and his external environment, which is influenced by previous experiences with other persons and objects in the external environment. Although it is recognized that the individual reacts to inanimate objects in the physical setting, for the purposes of this study, emphasis will be placed on the individual's interaction with one or more persons in his social milieu. The individuals involved in an interpersonal relationship interact as participants and as observers, each assuming an active part in a particular situation by observing the response of the other and reacting on the basis of this observation.

Intrapersonal Relationship:[30] Phenomena, experiences, or interactions occurring within the individual and ultimately affecting his behavior. This behavior is determined, in part, by the individual's past experience with intrapersonal relationships. Intrapersonal relationships are continuous and therefore occur during all interpersonal relationships, thereby affecting and being affected by them. For the purposes of this study, the term "intrapersonal relationship" shall be used interchangeably with the terms "intrapersonal interaction" and "intrapersonal experience."

Nurse-Patient Interaction:[31] The purposeful, planned behavior of the nurse that has an effect or influence on the patient and that, in turn, is affected or influenced by the patient's response. Therefore, the nurse-patient interaction is a dynamic two-way process. The behaviors of the nurse and the patient combine to bring about mutual, although not necessarily similar, changes in the thoughts, feelings, and behaviors of the two persons involved.

Nurse-Patient Relationship:[32] An interaction process necessarily involving the nurse and the patient in fairly prolonged contact over a period of time. The nurse offers a series of purposeful activities and practices based on a body of theoretical and empirical knowledge, with the goal of fostering the patient's physical, social, and emotional well-being. This relationship differs from a social relationship, in which two persons interact primarily for reasons of pleasure or companionship, with neither person in a position of responsibility for helping the other.

The nurse-patient relationship takes place in the daily living situation in which the nurse and the patient find themselves and is consistent with the

over-all treatment goal for the patient determined by the interdisciplinary team. It is not an end in itself, but rather a means through which (1) other aspects of nursing care are facilitated and can be made more effective, and (2) the patient experiences a meaningful, healthy, satisfying interpersonal relationship, to the end that he may be able to transfer that which he has learned from this relationship to his relationships with others.

The goals of the nurse in a nurse-patient relationship are based on the needs of the patient and are designed to provide opportunities that will help the patient to grow emotionally. They include helping the patient to (1) maintain himself biologically; (2) identify, state, and meet his specific and concrete needs whenever possible; (3) clarify his feelings; (4) participate with others; (5) communicate with others; (6) increase his self-esteem; (7) increase his comfort and minimize his anxiety; and (8) test reality.

The nurse helps the patient to achieve these goals through the use of both verbal and nonverbal communication and by employing the following purposeful and planned attitudes and activities based on her knowledges and abilities: acceptance, respect, sensitivity, support, reassurance, encouragement, empathy, understanding, limit-setting, and consistency. The nurse deals only with conscious material and does not make dynamic interpretations of meaning to the patient. She focuses on strengthening areas of health. Emphasis is placed on current problems of the patient's living with others in the ward setting. The manner in which and the degree to which these attitudes and practices are implemented and manifested are determined to a great extent by the nurse's own unique personality and the degree of her self-understanding, self-acceptance, and educational preparation.

The nurse-patient relationship is artificially divided into three phases of development. In reality, these phases cannot be isolated, but tend to overlap.

The first phase is initiating the relationship. This phase is centered upon mutual attempts to know each other and to help the patient become oriented to his environment. The commencement of this phase is the responsibility and the function of the nurse, although in some instances the patient may take the initiative. Establishment of the foundations of acceptance and mutual trust is the predominant feature of this phase.

The second phase is continuing the relationship. The focus of this phase is on helping the patient to benefit from the interaction through the use of the attitudes, the activities, and the practices stated above.

The third phase is concluding or terminating the relationship. This phase is concerned with helping the patient to transfer his healthy modes of interaction from the nurse to others in his social milieu, both within and outside the hospital.

The nurse is supervised in this relationship, preferably by an experienced nurse with professional preparation.

Nursing Intervention: The purposeful, individualized, planned activity of the nurse, designed to help the patient regain psychophysiological homeostasis in a specific crisis situation associated with his illness. This crisis

situation is a result of a psychophysiological disequilibrium caused by either internal or external forces with which the patient cannot cope unaided.

In psychiatric nursing, nursing intervention--the purposeful, individualized, planned activity of the nurse--is designed to help the patient deal with an increase in anxiety engendered by a specific crisis situation associated with his illness. This crisis situation can be a result of either increased intrapsychic conflicts or environmental forces with which the patient cannot cope unaided.

Therapeutic Use of Self:[33] The nurse's employment of her own unique personality in interactions with an individual patient or a group of patients, with the goal of helping to produce a beneficial effect on those involved. The nurse's therapeutic use of self is an integral part of the nurse-patient relationship.

That the effect of this interaction is potentially beneficial is based on the following assumptions:

1. Helping patients to change their behavior as one way of improving their intrapersonal and interpersonal relationships is an appropriate goal of psychiatric nursing.[34]
2. Changes in patient behavior occur as a result of emotional experiences.[35]
3. One way in which a patient has emotional experiences is through interactions with the nurse.
4. These interactions are beneficial only if the nurse manifests an attitude of acceptance toward the patient.[36]
5. The nurse cannot truly accept the patient unless she accepts herself.
6. Since the nurse is a unique individual with a personality that differs from the personality of any other individual, it is necessary for her to continually grow in self-awareness so that she may be self-accepting.
7. Self-awareness and self-acceptance enable the nurse to manifest behavior that is consistent with her thoughts and feelings.
8. Consistency of the nurse's thoughts and feelings with her behavior constitutes a therapeutic asset.[37]

Nursing Care Plan:[38] A written evaluation of the patient's individualized nursing care needs, along with suggestions as to how these needs may best be met. Developing a nursing care plan is essentially a problem-solving process and requires that the nurse have ability to:

1. Identify the needs of the patient, including priorities of need.
2. Understand the possible reasons for the existence of these needs.
3. Identify appropriate nursing care, including priorities of care.
4. Understand how and why this nursing care may meet the patient's needs.

The nursing care plan is designed to guide the nurse in giving effective nursing care and is therefore developed prior to the administration of the care. However, the nursing care given on the basis of the initial nursing care plan is evaluated, and the plan is then revised accordingly. In fact, planning nursing care is an ongoing process subject to evaluation and revision as the needs of the patient change, as more information is gathered, and as greater depth of understanding of the patient is attained. Evaluation of the nursing care plan (reporting and describing the nursing care given and the patient's responses) forms the essence of the nurse's notes.

Contributions to the nursing care plan are made by all nursing personnel concerned with the care of the patient, taking into consideration the total plan of care developed by the interdisciplinary team. The use of the nursing care plan by all nursing personnel facilitates communication and continuity of patient care.

Although the nurse and the nursing team may increase their knowledge about a specific patient and their skill in rendering nursing care through the use of a nursing care plan, a nursing care plan is not essentially a teaching tool but rather a device designed to help in the provision of consistently effective nursing care to patients. Therefore, it is appropriately used in all instances in which a patient is in need of nursing care services.

Therapeutic Environment: A milieu designed to help patients develop a sense of self-esteem and personal worth, to improve their ability to relate to others, to help them learn to trust others, and to return them to the community better prepared to resume their roles in living and working.[39]

In order to be therapeutic, the patient's environment must be purposeful and planned, taking into consideration physical aspects--i.e., homelike colors, furniture, et cetera, and provision for privacy; personal aspects--i.e., provision for physical needs such as food, cleanliness, rest, safety, et cetera, and acceptance in a friendly, warm atmosphere; and social aspects--i.e., provision for interaction and communication among patients and personnel.

A therapeutic environment meets the basic needs of the individual and provides a testing ground for the patient for new patterns of behavior.[40] It is based on a sound basic understanding of psychodynamics by the staff.

A therapeutic environment respects the individuality of each patient and at the same time provides for participation in democratic group activity. Emphasis is placed on socializing activities, for which the patients are encouraged to take increasing responsibility. Free-flowing communication among patients and staff, among patients, and among staff is essential.

A true therapeutic environment cannot be achieved unless an atmosphere of acceptance and optimism prevails throughout the unit. Any serious personal or professional conflict between staff members must be recognized and dealt with.

The setting of limits is not inconsistent with the concept of the accepting, permissive, democratic atmosphere of the therapeutic environment, but rather is an essential part of it and reflects the realities of living in a democratic society.

The environment can be said to be therapeutic only if the philosophy is consistently implemented over the period of time that the patient is in the hospital. Consequently, it can be seen that the major responsibility for providing a therapeutic environment rests with the nursing personnel, the group of workers who are in the closest continual contact with the patients.

Continual appraisal, evaluation, and modification are mandatory if the therapeutic environment is to be a dynamic living force that helps patients to move in the direction of health.

References

1. Benjamin S. Bloom, ed. Taxonomy of Educational Objectives. New York, McKay, 1956, pp. 28-29.
2. C. M. Lindvall, ed. Defining Educational Objectives. Pittsburgh, Univ. of Pittsburgh Press, 1964, p. 13.
3. Bloom. Op. cit., pp. 38-39.
4. Ibid.
5. Lindvall. Op. cit., p. 14.
6. David R. Krathwohl, Benjamin S. Bloom, and Bertram B. Masia. Taxonomy of Educational Objectives II. New York, McKay, 1964, pp. 139-153.
   Loretta E. Heidgerken. Teaching and Learning in Schools of Nursing. Philadelphia, Lippincott, 1965, pp. 148-149.
7. Lindvall. Op. cit., p. 14.
8. Heidgerken. Op. cit., pp. 53-110.
9. Doris A. Geitgey and D. Crowley. "Preparing Objectives." Amer. J. Nurs. 65:95-97, Jan. 1965.
   Lindvall. Op. cit., p. 14.
   R. F. Mager. Preparing Objectives for Programed Instruction. San Francisco, Fearon, 1962, pp. 6, 13-14, 53.
10. Ibid.
11. Ralph W. Tyler. Basic Principles of Curriculum and Instruction. Chicago, Univ. of Chicago Press, 1950, p. 69.
12. Heidgerken. Op. cit., pp. 114-164.
13. Tyler. Op. cit., p. 41.
14. Heidgerken. Op. cit., p. 99.
15. Lindvall. Op. cit., pp. 41-42.
16. American Nurses' Association. Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper. New York, the Association, 1965.
17. John G. Petty. "Psychiatric Nursing Education in Diploma Schools of Nursing," in Education and Supervision in Mental Health and Psychiatric Nursing. New York, NLN, 1963, pp. 32-33.
18. Frances Reiter Kreuter. "What is Good Nursing Care?" in Viewpoints on Curriculum Development. New York, NLN, 1957, p. 41.
19. Milton J. Lesnik and Bernice E. Anderson. Nursing Practice and the Law. Philadelphia, Lippincott, 1955, pp. 258-279.
20. Ibid.
21. Kreuter. Op. cit.
22. Ruth Matheney and Mary Topalis. Psychiatric Nursing. St. Louis, C.V. Mosby, 1965, p. 13.
23. Joyce Samhammer Hays. "The Psychiatric Nurse as Sociotherapist." Amer. J. Nurs. 62:64-67, June 1962.
24. Dorothy Mereness and Louis J. Karnosh. Essentials of Psychiatric Nursing. St. Louis, C. V. Mosby, 1966, p. 4.
25. Statement on Psychiatric Nursing Practice. American Nurses' Association, Division of Psychiatric-Mental Health Nursing, 1967.
26. C. Kenneth Beach. Technical Occupations in the State of New York. Albany, New York State Bureau of Industrial and Technical Education--University of the State of New York, 1946, p. 1.
27. Mildred L. Montag. Community College Education for Nursing. New York, McGraw-Hill, 1959, p. 144.
28. Ibid., p. 146.

2

29. Martha M. Brown and Grace R. Fowler. Psychodynamic Nursing--A Biosocial Orientation. Philadelphia, Saunders, 1961, p. 108.
Charles K. Hofling, Madeleine M. Leininger, and Elizabeth Bregg. Basic Psychiatric Concepts in Nursing. Philadelphia, Lippincott, 1967, p.35.
Marguerite Lucy Manfreda. Psychiatric Nursing. Philadelphia, F. A. Davis, 1964, p. 121.
30. Brown and Fowler. Op. cit., p. 109.
Hofling, Leininger, and Bregg. Op. cit., pp. 34-35.
31. Libby Zagorin. "Identification of the Components in a Therapeutic Nurse-Patient Relationship, Part II," in Psychiatric Nursing Concepts and Basic Nursing Education. Proceedings of the Conference at Boulder, Colorado. New York, NLN, 1960, p. 102.
32. Hays. Op. cit.
Hofling, Leininger, and Bregg. Op. cit., pp. 29-73.
Maurice Levine. "Principles of Psychiatric Treatment," in Franz Alexander and Helen Ross, eds. Dynamic Psychiatry. Chicago, Univ. of Chicago Press, 1952, pp. 307-366.
Carol A. Lindeman and Sister Edith Tuberty. Integration of Human Relations Content in Baccalaureate Nursing. St. Paul, Minn., College of St. Catherine, Dept. of Nursing, 1965, p. 42.
Manfreda. Op. cit., pp. 122-131.
Mereness and Karnosh. Op. cit., pp. 38-46.
Morris S. Schwartz and Emmy Lanning Shockley. The Nurse and the Mental Patient. New York, Russell Sage Foundation, 1956, pp. 244-281.
Zagorin. Op. cit., pp. 106-111.
33. Hofling, Leininger, and Bregg. Op. cit.
Matheney and Topalis. Op. cit.
Mereness and Karnosh. Op. cit.
34. Mereness and Karnosh. Op. cit., p. 4.
35. Matheney and Topalis. Op. cit., p. 89.
36. Ibid., pp. 76-84.
37. Ibid., p. 87.
38. Eleanor C. Lambertsen. Education for Nursing Leadership. Philadelphia, Lippincott, 1958, pp. 94-103, 162-165.
Thora Kron. Nursing Team Leadership. Philadelphia, Saunders, 1966, pp. 132-148.
Eleanor H. Muhs and Marjorie T. Nebesky. "A Psychiatric Nursing Care Plan." Amer. J. Nurs. 64:120-122, Apr. 1964.
Breda Nolan. Unpublished discussion at Meeting of Consultant Group on Associate Degree Education, Psychiatric Nursing Project, NLN, Jan. 11-13, 1966.
Doris R. Schwartz. "Toward More Precise Evaluation of Patient's Needs." Nurs. Outlook 13:42-44, May 1965.
39. Mereness and Karnosh. Op. cit., pp. 55-56.
40. Brown and Fowler. Op. cit., pp. 282-290.

APPENDIX B. WORKSHOP MATERIALS

SECTION 1. QUESTIONS FOR FACULTY DISCUSSION PRIOR TO THE WORKSHOP

Part A

1. What are the differences and similarities between mental health and psychiatric nursing content as the entire faculty sees them?

   a. Differences.

   b. Similarities.

2. What does the entire faculty consider to be mental health nursing content? Give examples and explain.

3. What does the entire faculty consider to be psychiatric nursing content? Give examples and explain.

4. On the basis of the responses to the three previous questions, is it appropriate for all clinical nursing courses to include psychiatric-mental health nursing content? Explain.

Part B

1. Trace one area of content other than psychiatric-mental health nursing throughout your curriculum. (Worksheets and directions are included for your use, if desired. See sections 2 and 3.)

2. Trace one area of psychiatric-mental health nursing content throughout your curriculum. Show how it progresses. (Worksheets and directions are included for your use, if desired. See sections 2 and 3.)

3. List all additional psychiatric-mental health nursing content that is currently being integrated into your curriculum.

4. What specific problems has the entire faculty encountered in integrating the psychiatric-mental health nursing content throughout the curriculum?

Part C

1. Describe and explain those competencies expected of the students at the completion of the program that include or indicate the psychiatric-mental health aspects of nursing care.

SECTION 2. WORKSHEETS

OBJECTIVES	CONTENT		
	Knowledges	Skills and Abilities	Attitudes and Appreciations

LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS	TERMINAL EXPECTED COMPETENCIES

SECTION 3. DIRECTIONS FOR USE OF THE WORKSHEETS

1. If worksheets are used, begin with the first course in nursing, followed by the second, third, et cetera, and ending with the last course in nursing. Identify the courses by content area (medical-surgical nursing or nursing in physical illness, parent and child health nursing or pediatric nursing, et cetera). Please include all nursing courses in sequence.

2. Identify in each course the objectives that deal with the one area of content you have chosen to trace. If a nursing course does not have any objectives relative to this area of content, please indicate.

3. After the objectives are identified for the one area of content, develop the remaining columns so that they indicate a horizontal relationship, i.e., the content relates to the objectives, the learning experiences relate to the content, et cetera. If a column heading does not seem applicable to an objective, the column may be left blank.

4. Please be as specific as possible.

5. Use the headings that are applicable to your program.

SECTION 4. BIBLIOGRAPHY

Curriculum Development

Abdellah, Faye G., and others. Patient-Centered Approaches to Nursing. New York, Macmillan, 1960.

Bailey, June Teig. "The Critical Incident Technique in Identifying Behavioral Criteria of Professional Nursing Effectiveness." Nurs. Research, Oct. 1956, p. 53.

Bloom, Benjamin S., ed. Taxonomy of Educational Objectives. Handbook I: Cognitive Domain. New York, David McKay, 1956.

Fivars, Grace, and Gosnell, Doris. Nursing Evaluation: The Problem and the Process. New York, Macmillan, 1966.

Heidgerken, Loretta E. Teaching and Learning in Schools of Nursing, 3d ed. Philadelphia, Lippincott, 1965.

Krathwohl, David R., Bloom, Benjamin S., and Masia, Bertram B. Taxonomy of Educational Objectives. Handbook II: Affective Domain. New York, David McKay, 1964.

Lindvall, C.M., ed. Defining Educational Objectives. Pittsburgh, Univ. of Pittsburgh Press, 1964.

Mager, Robert F. Preparing Objectives for Programmed Instruction. San Francisco, Fearon, 1962.

National League for Nursing, Department of Diploma and Associate Degree Programs. Criteria for the Evaluation of Educational Programs in Nursing Leading to an Associate Degree. New York, the League, 1962.*

————. Criteria for the Evaluation of Educational Programs in Nursing Leading to a Diploma. New York, the League, 1962.*

————. Toward Excellence in Nursing Education. A Guide for Diploma School Improvement. New York, the League, 1964.*

Tyler, Ralph W. Basic Principles of Curriculum and Instruction. Chicago, Univ. of Chicago Press, 1950.

Ward Environment

Brown, Martha M., and Fowler, Grace R. Psychodynamic Nursing--A Biosocial Orientation, 2d ed. Philadelphia, Saunders, 1961, pp. 282-290.

Matheney, Ruth, and others. Fundamentals of Patient-Centered Nursing. St. Louis, C.V. Mosby, 1964, pp. 93-102.

Matheney, Ruth, and Topalis, Mary. Psychiatric Nursing, 4th ed. St. Louis, C.V. Mosby, 1965, pp. 95-104.

Mereness, Dorothy, and Karnosh, Louis J. Essentials of Psychiatric Nursing, 6th ed. St. Louis, C.V. Mosby, 1962, pp. 63-71.

Neylan, Margaret Prowse. "The Nurse in a Healing Milieu." Amer. J. Nurs. 61:72-74, Apr. 1961.

Noyes, Arthur P., Camp, William P., and van Sickel, Mildred. Psychiatric Nursing, 6th ed. New York, Macmillan, 1964, pp. 258-264.

Repella, James E. "The Nurse, the Patient, and Environmental and Nursing Therapy." J. Psychiat. Nurs. 1:16-20, Jan. 1963.

Siegal, Nathaniel. "What is a Therapeutic Community?" Nurs. Outlook, May 1964, pp. 49-51.

*Where applicable.

Group Work Skills

Eckelberry, Grace K. "Group Work Skills in Nursing Practice." Amer. J. Nurs. 52:1512-1514, Dec. 1952.

Hays, Joyce Samhammer. "The Psychiatric Nurse as Sociotherapist." Amer. J. Nurs. 62:64-67, June 1962.

Hilbarger, Victoria E., and others. "Nurses Use the Group Process." Amer. J. Nurs. 55:334-336, Mar. 1955.

Morimoto, Francoise R. "The Socializing Role of Psychiatric Ward Personnel." Amer. J. Nurs. 54:53-55, Jan. 1954.

Small, Iver S., and others. "Total Ward Therapy Groups in Psychiatric Treatment." Amer. J. Psychoth. 17:254-265, Apr. 1963.

Sommers, Robert. "Working Effectively with Groups." Amer. J. Nurs. 60:223, 1960.

Stevens, Leonard F. "Nurse-Patient Discussion Groups." Amer. J. Nurs. 63:67-69, Dec. 1963.

Community Mental Health--Trends

Action for Mental Health. Final Report of the Joint Commission on Mental Illness and Health. New York, Basic Books, 1961.

Mereness, Dorothy. "Problems and Issues in Contemporary Psychiatric Nursing." Perspectives in Psychiatric Care. Vol. II, No. 1, 1964, pp. 14-21.

Norris, Catherine M. "The Trend Toward Community Mental Health Centers." Perspectives in Psychiatric Care. Vol. I, No. 1, 1963, pp. 36-40.

SECTION 5. FORM FOR PARTICIPANTS' EVALUATION OF THE WORKSHOP

One form should be completed for each program and turned in at the end of the workshop. A duplicate may be retained by the participants.

Use blank sheets for responses and number accordingly. Please write name of program on each sheet.

1. What did your faculty find most helpful about the questions sent to your program prior to the workshop? Please explain.

2. Were any specific questions more helpful than others? Which ones and why?

3. What did your faculty find least helpful about the questions? Please explain.

4. Were any specific questions less helpful than others? Which ones and why?

5. What specific problems were encountered by the faculty in completing the questions (except for pressure of time)? Why?

6. Do you think the questions for faculty discussion and the bibliography adequately prepared you for participation in the workshop? In what way?

7. In terms of your program, list your plans for modifications in competencies (objectives), content, and learning experiences, et cetera, as a result of your participation in the workshop.

   a. Course or unit in psychiatric nursing or nursing care of the mentally ill.

   b. Other areas.

8. What problems do you anticipate in implementing your plans for these modifications?

   a. Course or unit in psychiatric nursing or nursing care of the mentally ill.

   b. Other areas.

9. In making plans for these modifications, what was most helpful about the workshop?

10. In making plans for modifications, what was least helpful about the workshop?

11. In what way(s) could the workshop have been more helpful?

12. List ways in which the project staff can be most helpful to your faculty in implementing your plans during their visits to your program in the coming year.

13. What materials do you think should be published from this project that would be helpful to associate degree or diploma nursing programs across the country in terms of:

    a. Integration of psychiatric-mental health content in the curriculum.

    b. Course or unit in psychiatric nursing or nursing care of the mentally ill.

APPENDIX C. WORKSHOP AGENDA

NATIONAL LEAGUE FOR NURSING
Mental Health and Psychiatric Nursing Advisory Service

Pilot Project: An Approach to the Teaching of
Psychiatric Nursing in Diploma and Associate Degree Programs

WORKSHOP FOR FACULTY FROM PARTICIPATING PROGRAMS

October 24-28, 1966
New York City

A G E N D A

Monday, October 24

8:00-9:00 a.m.	Registration	
9:00-9:30 a.m.	Introduction and Overview of Workshop Proceedings Greetings and Announcement of Continuing Education Grants under the National Institute of Mental Health	Joan E. Walsh, Project Director Winifred Maher, Training Specialist, Nursing Section, NIMH
9:30-10:00 a.m.	Psychiatric-Mental Health Nursing Activities in the NLN	Mary F. Liston, Ed.D., formerly Director, Division of Nursing Education, NLN, and Principal Investigator of the Project
10:00-10:30 a.m.	Progress Report on the Project	Joan E. Walsh
10:30-12 noon	Keynote Address--Integration of Psychiatric-Mental Health Nursing Content in a Curriculum	Mona Moughton, Instructor, Division of Nurse Education, School of Education, New York University
1:30-2:00 p.m.	Workshop Plans and Instructions for Participants	
2:00-3:00 p.m.	Discussion of Content--Individual Behavior and the Nurse-Patient Relationship	Cecelia A. Monat, Consultant to the Project
3:00-4:00 p.m.	Working Groups	

Tuesday, October 25

9:00-10:00 a.m.	Questions and Discussion of Content--Individual Behavior and the Nurse-Patient Relationship	
10:30-12 noon	Working Groups	
1:30-4:30 p.m.	Working Groups	

Wednesday, October 26

9:00-9:30 a.m.	Questions and Discussion	
9:30-10:30 a.m.	The Trend Toward Community Mental Health Centers	Wallace Mandell, Ph.D., Director, Research Division, Staten Island Mental Health Society
11:00-12 noon	Discussion of Content--Therapeutic Environment [not presented]	Joan E. Walsh
1:30-4:30 p.m.	Working Groups	

Thursday, October 27

9:00-10:00 a.m.	Discussion of Content--The Group Process	Cecelia A. Monat
10:00-10:30 a.m.	Questions and Discussion	
11:00-12 noon	Working Groups	
1:30-4:30 p.m.	Working Groups	

Friday, October 28

9:00-9:30 a.m	Questions and Discussion
9:30-12 noon	Working Groups--Complete Materials
1:30-3:30 p.m.	Participants' Reports Questions and Discussion
3:30-4:00 p.m.	Plans for Follow-up Visits Adjournment

APPENDIX D. ROSTER OF WORKSHOP PARTICIPANTS

Speakers

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